ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Accreditation Handbook

FOR AMBULATORY HEALTH CARE

2007

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION

Standards

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The pronouns used in the *Handbook* were chosen for ease of reading. They are not intended to exclude references to either gender.

Foreword

Another year has passed and yet another milestone has been reached by the Accreditation Association for Ambulatory Health Care (Accreditation Association/ AAAHC). The year 2006 was again a banner year for accreditation with more than a thousand accreditation surveys completed, a more than 20 percent increase from 2005. We have also accredited our 3000th organization. It was not that long ago that we reached the 2000th organization milestone; it has taken us only two years since then to realize a 50 percent growth in the number of accredited organizations.

We saw substantial growth last year in the number of ambulatory health care centers that recognize the importance of accreditation, continuing a trend that has been evident for the last six years. The steep rise in the number of AAAHC-accredited organizations reflects growth in the ambulatory health care arena and an expansion in the number and complexity of procedures performed in ambulatory settings. We expect the double-digit growth we have been experiencing in the number of AAAHC-accredited facilities to continue in the immediate future.

In 2006, ambulatory surgery centers (ASCs) represented the majority of AAAHC-accredited facilities, followed by office-based surgery (OBS) centers. The Accreditation Association has recently won the contract to accredit all United States Air Force ambulatory health care clinics and the United States Coast Guard has taken up its additional option year provided for under its current contract with the Association. Government contracts are therefore expected to be an important source of growth for the Accreditation Association.

The AAAHC standards have been developed with the intent to make them relevant and adaptable to all types of ambulatory health care organizations. They are meant to be incorporated into the routine policies and procedures of an accredited organization, such that compliance to the standards will be a regular part of the way an organization provides health care to its patients.

In our continuous effort to make the standards relevant to organizations, for 2007, the Accreditation Association Board of Directors has approved a new set of revisions to the standards. Substantial changes have been made to Chapter 17, Diagnostic and Other Imaging Services, and Chapter 24, Health Education and Health Promotion. For a summary of all the revisions, please refer to Appendix A of this Handbook.

We see the growth we have been enjoying as a testimony to the strength of our philosophy of providing a consultative and educational accreditation experience for our accredited organizations. We appreciate the support of our Board of Directors, volunteer surveyors, staff and accredited organizations in making this possible, and thereby consolidating our position as the leader in the accreditation of ambulatory health care organizations. We look forward to continuing to work with you to improve the level of quality care and patient safety through the process of accreditation.

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Acknowledgments

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Without the dedication and commitment of these individuals, this 18th edition of the *AAAHC Accreditation Handbook for Ambulatory Health Care* would not have been possible.

Contents

Accreditation Policies and Procedures

Eligibility for Survey

Any organization that meets the Survey Eligibility Criteria of the Accreditation Association for Ambulatory Health Care (Accreditation Association/AAAHC) may apply for an accreditation survey. The following types of organizations have found the AAAHC standards and survey procedures particularly appropriate and helpful in improving the quality of care they provide:

- Ambulatory health care clinics
- Ambulatory surgery centers
- Birthing centers
- College and university health centers
- Community health centers
- Dental group practices
- Diagnostic imaging centers
- Endoscopy centers
- Health Maintenance Organizations (HMOs)
- Independent Physician Associations (IPAs)
- Indian health centers
- Lithotripsy centers
- Managed care organizations
- Military health care facilities
- Multispecialty group practices
- Occupational health centers
- Office-based anesthesia organizations
- Office-based surgery centers and practices
- Oral and maxillofacial surgery practices
- Pain management centers
- Podiatry practices
- Radiation oncology centers
- Single specialty group practices
- Urgent or immediate care centers
- Women's health centers

Survey Eligibility Criteria

An organization is eligible for an accreditation survey by the AAAHC if the organization:

1. has been providing health care services for at least six months before the on-site survey, excluding organizations seeking accreditation through the AAAHC Early Option Survey (EOS) Program (see page 7 for details on the EOS Program)

2. is either a formally organized and legally constituted entity that primarily provides health care services, or a sub-unit that primarily provides such services within a formally organized and legally constituted entity that may be, but need not be, health related

3. is in compliance with applicable federal, state and local laws and regulations, or for organizations operating in Canada, applicable federal, provincial and local laws and regulations

4. is licensed by the state in which it is located, if the state requires licensure for that organization, unless the organization is applying for a survey that will be used to obtain licensure in a state that recognizes AAAHC accreditation for this purpose

5. provides health care services under the direction of one of the following health care professionals:

a. doctor of medicine or osteopathy (MD/DO)

b. doctor of dental surgery or dental medicine (DDS/DMD)

c. doctor of podiatric medicine (DPM)

d. doctor of optometry (OD)

e. doctor of chiropractic (DC)

(These individuals or groups of professionals must accept responsibility for the health care provided by the organization, and be licensed in accordance with applicable state laws.)

6. shares the facilities, equipment, business management and records involved in patient care among the members of the organization

7. operates in compliance with the U.S. Equal Employment Opportunity Commission Rules and Regulations

8. provides the signed *Application for Survey* and other documents in advance of the survey

9. pays the appropriate fees

10. acts in good faith in providing complete and accurate information to the AAAHC during the accreditation or reaccreditation process.

Organizations are considered for survey on an individual basis. The AAAHC determines whether the standards can be applied to any given applicant. A survey will not be conducted if the AAAHC decides that the standards cannot be applied. The AAAHC will inform the organization of the reason for such a decision and will refund the application fee. If a survey is conducted and the AAAHC decides that the standards cannot be appropriately applied in order to reach an accreditation decision, the survey will be deemed to be a consultation and no accreditation decision will be made. Fees for such a consultation will not be refunded.

Purpose and Application of the Standards

The standards contained in the *AAAHC Accreditation Handbook for Ambulatory Health Care* have been developed to encourage the voluntary attainment of high-quality care in organizations providing health care services in ambulatory settings. The standards describe characteristics that the AAAHC believes to be indicative of an accreditable ambulatory health care organization.

Most standards are written in general terms, to allow an organization to achieve compliance in the manner that is most compatible with its particular situation and most conducive to the attainment of high-quality patient care. Where the acceptable methods of achieving compliance with a standard are limited, the standard is written in specific terms. Whether a standard is stated in general or specific terms, the AAAHC is concerned about compliance with the intent of the standard first and with the letter of the standard second.

Throughout the *Handbook,* reference is made to specific documents or standards published by other organizations. Subsequent editions of these publications have become the authoritative reference of the AAAHC only after they have been approved as such by the Board of Directors. All organizations seeking accreditation, regardless of name, mission statement or primary service provided, must meet the same high standards described in the *Handbook.*

Regardless of the type of organization surveyed, the applicable portions of the core standards, Chapters 1-8, titled Rights of Patients, Governance, Administration, Quality of Care Provided, Quality Management and Improvement, Clinical Records and Health Information, and Facilities and Environment, will be applied to the organization seeking an accreditation survey. The adjunct standards, Chapters 9-24, will be applied as appropriate to the services provided by the organization. For example, immediate/urgent care centers, radiation oncology centers and occupational health centers must be in compliance with the respective adjunct standards for these settings in the *Handbook,* as well as in compliance with all core standards and other adjunct standards, such as laboratory and radiology services, if applicable.

Likewise, ambulatory surgery centers and office-based surgery practices must meet the core standards, plus the adjunct standards for Anesthesia Services and Surgical and Related Services, as well as all other relevant adjunct standards. Certain large multispecialty group practices or hospital-sponsored ambulatory health care programs may find that all of the adjunct standards in the *Handbook* will be applicable. Any questions about the applicability of the standards should be addressed to the AAAHC office.

The AAAHC welcomes comments or suggestions regarding the reasonableness or clarity of any of its standards. Any proposed revisions, deletions or additions to the AAAHC standards recommended by the Standards and Survey Procedures Committee are subject to a public comment period of 30 days. The AAAHC solicits comments regarding proposed revisions to the standards from its member organizations and other interested parties identified by the AAAHC.

The Standards and Survey Procedures Committee submits to the AAAHC Board of Directors, for review and final approval, any recommended revisions or additions to the existing standards, all relevant public comments received and any other recommendations the Committee makes in response to the comments.

An organization will be surveyed according to the 2006 standards if the *Application for Survey* is received at the AAAHC on or before February 28, 2007 and the organization's survey begins on or before June 30, 2007. An organization will be surveyed according to the 2007 standards if the *Application for Survey* is received at the AAAHC office on or after March 1, 2007, and/or the organization's survey begins after June 30, 2007.

Principles Governing Accreditation Survey Procedures

The accreditation decision is based on a careful and reasonable assessment of an organization's compliance with applicable standards and adherence to the policies and procedures of the AAAHC. The AAAHC reserves the right to amend its policies and procedures from time to time, provided that all accredited organizations are notified of such changes, or such changes are included in the most recent edition of the *Handbook*.

The AAAHC expects substantial compliance with the applicable standards. Compliance is assessed through at least one of the following means:

1. documented evidence
2. answers to detailed questions concerning implementation
3. on-site observations and interviews by surveyors.

Information provided by an organization seeking AAAHC accreditation or reaccreditation is a critical component of the assessment process. The accuracy and veracity of that information is essential to the integrity of the AAAHC's accreditation program. Such information may be verbal in nature, may be obtained through direct observation by AAAHC surveyors or may be derived from documents supplied by the organization. The AAAHC requires that each organization enter into the accreditation or reaccreditation process in good faith.

Failure to participate in good faith during the accreditation process, including, but not limited to, the submission to the AAAHC of falsified, inaccurate or incomplete documents or information, may be grounds for denial or revocation of an organization's accreditation status the basis for terminating an application or an appeal, ceasing to do business with the organization or for granting a lesser term of accreditation, without the right of the organization to appeal or reconsider any such action by the AAAHC. In the event an application or appeal is terminated, the AAAHC is entitled to retain the application and survey fees or any other applicable fees paid by the organization.

An organization's duty to provide information continues during the entire accreditation process. If an organization experiences significant changes after it submits its *Application for Survey,* but before an accreditation decision is reached, the organization must notify the AAAHC in writing within five (5) business days of this change. Failure to notify the AAAHC promptly may result in immediate termination of an application for accreditation or immediate revocation of accreditation.

An accreditable organization will not be held in noncompliance with the standards if the governing body approves non-physician health professionals to carry out specific examinations or procedures, order laboratory tests or radiological studies, provide treatment or conduct or supervise health care services, so long as any of these activities are specifically authorized or mandated by state law governing the practice of medicine or other health care professions.

Survey Process

Although the accreditation survey process is of necessity evaluative, the AAAHC emphasizes the educational and consultative benefits of accreditation. Consequently, the AAAHC uses health care professionals and administrators who are actively involved in ambulatory health care settings to conduct accreditation surveys. These dedicated individuals volunteer their time to be trained and to serve as surveyors. The primary objective of the training is to teach them to use their practical knowledge in the consistent application of the standards.

Each accreditation survey is tailored to the type, size and range of services offered by the organization seeking accreditation. The length of the on-site visit and the number of surveyors used by the AAAHC are based on a careful review of the information provided in the *Application for Survey* and supporting documents submitted by the organization.

Accreditation decisions are made by the AAAHC Accreditation Committee after careful review of the survey reports, any other applicable supporting documents, and recommendations of surveyors and staff. All documents reflecting the opinions or deliberations of any surveyor, staff member, member of a committee of the AAAHC or its officers or directors constitute peer review materials and will not be disclosed to the organization seeking accreditation or to any third party. Accreditation is awarded to organizations that demonstrate substantial compliance with the standards and adhere to the AAAHC accreditation policies. The degree and number of variations in compliance, as well

as the importance of a particular deficiency in a specific organization, determine the length of the accreditation term. Organizations will receive a copy of the factual findings from the survey, as part of the survey process.

Survey Procedures

The survey of a health care organization is conducted by surveyors selected and trained by the AAAHC. Surveyors are physicians, dentists, podiatrists, pharmacists, registered nurses, ambulatory health care facility administrators and other health cae professionals who are in active practice and/or have substantial experience in ambulatory health care. Specific survey team members are selected, to the extent possible, on the basis of their knowledge of and experience with the range of services provided by the organization seeking an accreditation survey, as well as with its type, size and location. In the interest of objectivity, the AAAHC cannot honor requests for specific surveyors. The survey is conducted in accordance with the procedures discussed with the organization before the on-site survey. These procedures enable the surveyors to gather information with minimal disruption of the daily activities of the organization being surveyed. Organizations are asked in advance to have specified documents and other information available to the surveyors during the on-site visit. They are also asked to submit other documents directly to the AAAHC in advance of the survey. Surveyors may, however, ask to see additional documents or may request additional information during the on-site survey. For organizations that perform surgeries or procedures, it is necessary for the surveyor(s) to observe a surgery or procedure.

Failure by the organization to provide any information requested by the AAAHC or a surveyor or to allow a surveyor to observe a surgery or procedure may be grounds for termination of an application for survey.

At the conclusion of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. As the surveyors are "fact finders" for the AAAHC and do not render the final accreditation decision, no information regarding the organization's compliance with the AAAHC standards or the accreditation decision is provided during this conference. Members of the organization's governing body, medical staff and administration are encouraged to take this opportunity to comment on or rebut the findings as well as express their perceptions of the survey.

After the accreditation survey is completed, a survey evaluation form is provided to the surveyed organization to enable the organization to evaluate surveyor performance, the reasonableness of the standards and the value of the consultation and education provided to the organization's staff. It also enables the organization to evaluate the survey process in terms of its effect on improving the quality of care provided. The information provided by the organization on the evaluation form is strictly confidential and in no way impacts the accreditation decision.

Application and Self-Assessment

The *Application for Survey* and *Self-Assessment Manual* discussed below may be obtained by any interested individual by visiting the AAAHC Web site, *www.aaahc.org*, or by calling the AAAHC at 847/ 853-6060. There is a fee for obtaining the *Self-Assessment Manual.*

The *Application for Survey* requires an organization to verify its compliance with the survey eligibility criteria. It must be completed by each organization requesting a survey. Except where prohibited by law, a nonrefundable application fee must accompany each application. In signing the application, the organization attests to the accuracy and veracity of the statements in the application and other information and documents provided to the AAAHC and to the survey team during the survey process. Also, in signing the application, the organization agrees to comply with all currently applicable AAAHC policies and procedures.

The *Application for Survey* also enables the AAAHC to assess the organization's governing structure and the extent and type of health care services offered. It must be submitted along with the supporting documents prior to a survey being scheduled. Surveyors and staff will review the *Application* and may request clarification of any information contained therein.

An *Application for Survey* is valid for six months from the date of receipt by the AAAHC. If the application is incomplete when received, and is not completed within six months, or if the organization does not schedule a survey during the six-month period, the application will expire and the organization will need to submit a new *Application for Survey,* along with an additional application fee.

The *Self-Assessment Manual* is an optional tool that enables an organization to evaluate its own compliance with the standards. Forms are provided to facilitate the assignment of various standards to the organization's staff for review, to outline a chronological sequence in preparation for

survey and to enable staff to focus on areas that are in less than substantial compliance with the standards. The *Self-Assessment Manual* follows the same format used by AAAHC surveyors in completing a *Survey Report Form* during a survey.

Scope of Surveys, Survey Fees, Schedules and Cancellation Policies

The scope of the survey is determined by AAAHC staff and discussed with the organization prior to the survey. Questions regarding the scope of the survey should be directed to the AAAHC office.

The survey fee is determined based upon information obtained from the organization's *Application for Survey* and supporting documentation. Factors considered in determining price include the size, type and range of services provided by the organization. An invoice will be sent when the survey date has been determined. Except where prohibited by law, the survey fee must be paid no later than 20 days in advance of the survey date. Failure to pay the survey fee in advance will result in cancellation of the survey.

Survey dates are determined by the AAAHC in cooperation with the organization being surveyed. Every attempt is made to schedule the survey at a convenient time for the requesting organization.

Once a survey has been scheduled, AAAHC sends the organization a confirmation of the date(s) of the survey, the name(s) of the surveyor(s) who will conduct the survey, the survey schedule, and other information about the review. (Specific dates and survey names are not provided for AAAHC/Medicare deemed status surveys.)

A request for postponement or cancellation of a scheduled survey must be received by the AAAHC in writing. If an organization cancels or postpones its survey 30 days or more prior to the survey, the entire fee is refundable. If the organization cancels or postpones its survey between 15 and 29 days before the survey, the AAAHC will assess the organization a $500 administrative fee and, in addition, the organization is responsible for all direct and indirect nonrefundable costs associated with the survey, including any airline tickets. If the organization cancels or postpones its survey less than 15 days before the survey, no refunds will be given and the organization is expected to pay the complete survey fee.

If an organization cancels or postpones a scheduled survey more than one time, additional fees will be assessed at the discretion of the AAAHC and the fee must be paid prior to scheduling the next survey.

Multisatellite Organizations

For organizations with multiple service locations, AAAHC staff will determine which service sites will be visited on any survey. When an organization has service sites in more than one state, at least one site in each state will be visited. If the organization indicates that a service location should not be reviewed, this site will not be eligible for accreditation and will not be listed on the Certificate of Accreditation.

Inclusion of Related Patient Care Entity or Service

The accreditation site survey includes a comprehensive review of all aspects of the organizational legal entity, or sub-unit of a legal entity, seeking accreditation. When the organization seeking accreditation has a close interrelationship with a separate related patient care entity or service, the survey will include a review of the components outside the boundaries of the legal entity or entity sub-unit seeking accreditation if: (1) there are AAAHC standards applicable to the related entity or service; **and** (2) the related entity or service is organizationally and functionally integrated with the applicant organization; **and/or** (3) the related entity or service is represented or reasonably appears to the public as being part of the applicant organization.

In cases where items 1 and 2 or 1 and 3 above are not met, but there is sufficient relatedness between the services and the applicant organization to suggest that the service or related entity functions as part of the applicant organization or reasonably appears to do so, both the applicant organization and the service or related entity will be included in the survey process.

For example, an ambulatory surgery center (ASC) organized as a distinct legal entity is surveyed to assess compliance with the AAAHC standards. The survey will normally include a review of components of a separate, but related, medical practice (*e.g.*, corresponding clinical records, shared space or resources) to provide relevant information to determine compliance with the standards. However, any accreditation decision conferred will apply solely to the legal entity seeking accreditation even though (an)other related entity(ies) was included in the survey review process.

Although in general the AAAHC surveys and accredits a single legal entity, it will review a sub-unit of a survey-eligible legal entity, if requested, when the sub-unit exhibits autonomous characteristics and demonstrates the capability to meet the AAAHC standards on its own.

Organizational integration* exists when the applicant organization's governing body, either directly or ultimately, controls the budgetary and resource allocation decisions for the related entity or service. Where separate corporate entities are involved, organizational integration also exists when there is greater than 50 percent of the same governing body membership on the board of the applicant organization and the board of the other entity.

Functional integration* exists when the entity meets four of the following criteria, including either criterion 1 or 2:

1. There is a common organized medical or professional staff for the applicant organization and the related entity.
2. The applicant organization's human resources function is responsible for all staffing of the related entity or service and development and implementation of established personnel activities.
3. The applicant organization's policies and procedures are applicable to the related entity or service, with few or no exceptions.
4. The applicant organization manages all operations of the related entity or service, *i.e.*, the related entity has little or no management authority or autonomy independent of the applicant organization.
5. The related service or entity's patient records are integrated into the applicant organization's record system (or vice versa).
6. The applicant organization applies its quality improvement program to the related entity or service and has authority to implement actions intended to improve the performance at the related entity or service.
7. The applicant organization bills for services provided by the related entity or service under the name of the applicant organization.
8. The applicant organization occupies physically connected floor space and/or a geographic location with the related entity or service such that the related entity or service is represented or reasonably appears to the public as being part of the applicant organization.

* Organizational and functional integration refer to the degree to which the service or related entity is overseen and managed by the applicant organization.

Types of Surveys

Consultative Surveys

The AAAHC provides a consultative survey for any organization desiring additional help in understanding the standards, preparing for accreditation, or achieving compliance with a particular standard. Consultation allows the participating organization to seek assistance in meeting specific needs. This includes specifying areas to be reviewed, as well as the number of surveyors. Fees for consultative surveys will be assessed at the prevailing rate.

By definition, on-site consultation does not result in an accreditation decision. Problems are identified and suggestions for improvement are made, but all reports of findings are strictly for the use of the requesting organization. The consultation may be one or two days in length with one or more surveyors. For consultative surveys only, organizations may request specific surveyors (pending availability).

Consultative surveys may be held any time the organization requests, provided the organization is open and operating. Consultation from the AAAHC cannot be part of pre-construction or pre-opening planning.

As with all AAAHC surveys, to initiate a consultative survey, the organization must submit the *Application for Survey* and the supporting documentation. For an accreditation survey that follows a consultative survey, a new application and application fee is required if the organization does not request the accreditation survey within 12 months following receipt of the application that was submitted for the consultative survey.

Managed Care Surveys

Managed care organizations are surveyed using a sampling plan. The sampling methodology combines visitations to selected primary care and specialist provider sites with a review of a sampling of medical records. The selection of providers and the number of medical records to be reviewed is made by AAAHC staff in consultation with the organization.

Early Option Survey Program

The AAAHC's Early Option Survey (EOS) program is for organizations that (1) require accreditation for purposes of meeting state regulations that require accreditation before the facility can legally begin operations; or (2) are newly constructed and operational and require accreditation for health insurance, managed care or other third-party reimbursement, and a six-month wait for a survey would entail financial hardship.

The eligibility criteria for an organization to participate in the AAAHC EOS program are the same as the regular AAAHC eligibility criteria, except that the requirement that an organization has been providing health care services for at least six months before the on-site survey is conducted is waived when the factors described above are present and the organization has requested such a waiver.

Any organization requesting a survey through the AAAHC EOS program must submit an *Application for Survey,* application fee and supporting documentation. In addition, the organization needs to submit evidence of the following:

- licensure or provisional licensure has been obtained from the state in which the organization operates (if the organization is not subject to a facility licensure law in its state, then it should provide a statement from the state agency attesting to this fact); if an organization's state requires a licensure survey just prior to opening for preliminary licensure, verification of the preliminary license or survey may be obtained by the survey team at the time of the EOS;
- the building in which patient care services will be delivered is built and ready to support patient care service delivery;
- all policies and procedures, bylaws, governance and administrative structures are in place;
- key executive and medical staff have been employed by the organization;
- all necessary equipment is in place and has been appropriately tested and/or calibrated with up-to-date maintenance logs in place;
- the date to begin operations has been identified.

Organizations participating in the EOS program are eligible for a maximum of a one-year term of accreditation from the EOS. (Refer to one-year and six-month terms of accreditation on page 9.)

Initial Accreditation Surveys

Initial accreditation surveys are conducted for organizations that have been providing services for six months or more when AAAHC accreditation is sought for the first time.

Reaccreditation Surveys

Reaccreditation surveys are conducted for organizations that are currently AAAHC accredited and seek reaccreditation following a three-year term. See "Maintaining Accreditation" (on page 10) for additional information.

Random Surveys

To support the AAAHC's ongoing quality assurance initiatives, an accredited organization may be selected for a random survey from 9 to 30 months after an accreditation survey. Random surveys are unannounced. Organizations are selected on a proportionate basis across practice settings, geographic areas and accreditation decision categories. These unannounced surveys, which are conducted by one surveyor and may last one full day, are a means by which the AAAHC can evaluate the consistency and quality of its program, while also demonstrating to the public and regulators that accredited organizations remain committed to our standards throughout the accreditation cycle. They also provide the AAAHC and its surveyors with the opportunity to further consult with accredited organizations in the interval between regular surveys. No fee shall be charged to the organization when a random survey is initiated.

Discretionary Surveys

Discretionary surveys are conducted "for cause," when concerns have been raised over an organization's continued compliance with standards. An accredited organization may be scheduled for a discretionary survey with or without advance notice, at any time, and at the discretion of the AAAHC. No fee shall be charged to the organization when a discretionary survey is initiated.

If AAAHC conducts a random or a discretionary survey and the surveyed organization is judged not to be in substantial compliance with the standards, its accreditation will be revoked or reduced. (Refer to Denial or Revocation of Accreditation, page 10.)

Public Notice of Survey and Presentation of Information by Individuals

AAAHC policy requires that for all surveys, a notice of the date(s) of survey and a notice inviting interested individuals to present relevant information be posted prominently throughout the organization's premises 30 days before the scheduled survey date(s). To assist organizations and to ensure consistency in posting public notice, the AAAHC sends copies of the *Notice of Accreditation Survey* form to each organization for posting. (The notice is also available on the AAAHC Web site at *www.aaahc.org.)* The organization may photocopy additional copies to achieve wide distribution.

As stated in the *Notice of Accreditation Survey,* during the on-site survey the AAAHC provides an opportunity for members of the general public, as well as patients and staff of the organization, to present to AAAHC surveyors pertinent and valid information about the surveyed organization's provision of health care or its compliance with the AAAHC standards. Alternatively, individuals may present such information in writing to the AAAHC office. All information received from individuals will be considered in the accreditation process.

The opportunity for individuals to present information in person is usually scheduled during the morning of the first survey day and normally does not exceed one hour in length. The time and length of the session should be agreeable to all parties concerned, but final authority for such matters rests with the chairperson of the survey team. The surveyed organization will provide reasonable accommodations for the session, which is chaired by the AAAHC surveyor.

The session will consist of the orderly presentation of information, verbally or in writing, within the scheduled time. All information received will be considered for pertinence and accuracy, and the findings may be included in the survey report if applicable.

A request to present information during the on-site survey must be received at least two weeks before the survey date(s) to allow time to schedule the session. The organization to be surveyed will refer to the AAAHC any such requests it receives. The AAAHC will acknowledge each and send a copy of the acknowledgment to the organization surveyed. Requests received directly by the AAAHC will be acknowledged in the same manner. The organization to be surveyed is responsible for informing the requesting individual of the date, time and place for the presentation of information to the surveyor.

The AAAHC requires managed care organizations to provide notice to staff of the organization and members of the plan, as well as providers (either through employment or by contract). To comply with the AAAHC policy, notice may be given in one of many ways (*e.g.*, announcement in the member or provider newsletter, special bulletins distributed to staff, members or providers or an advertisement in the local newspaper). Organizations may utilize other means of notification, but need to obtain approval by AAAHC staff that the requirements of the policy are being met.

If the organization refuses to post the notice before the survey, the survey will not be conducted. If the organization unintentionally fails to post the notice, the survey will be conducted, but no accreditation decision will be made until the organization posts the notice for 30 days. This is to allow interested individuals time to request the opportunity to present information relevant to the survey. If such a request is received, a surveyor will be sent, at the surveyed organization's expense, to receive the information.

Accreditation Decision and Notification

The AAAHC carefully reviews each survey report, surveyor and staff recommendations, and any other relevant information before making an accreditation decision. A surveyor, staff member or member of the AAAHC Board of Directors who is in any way affiliated with an organization, or whose participation represents a conflict of interest, is not allowed to participate in deliberations or voting relative to the accreditation status of that organization. The organization will be notified of the accreditation decision.

In the event that accreditation is granted for less than three years, the organization has the right to submit additional materials and request reconsideration of the term of the accreditation. In the event that the decision is to deny or revoke accreditation, the organization generally has an opportunity to provide additional information before a final decision is rendered and the decision is subject to a right of appeal. When the accreditation decision is based upon findings from an AAAHC survey, the decision is based on the organization's compliance with the AAAHC's standards in effect at the time of the survey.

Terms of Accreditation

The following terms of accreditation may be awarded:

Three Years

The AAAHC awards accreditation for three years when it concludes that the organization is in substantial compliance with the standards, and the committee has no reservations about the accuracy of the survey findings or the organization's commitment to continue providing high-quality care and services consistent with the standards.

One Year

The AAAHC awards accreditation for one year when a portion of the organization's operations are acceptable, but other areas need to be addressed and the organization requires time to achieve and sustain compliance with all AAAHC standards. The organization must have a re-survey within ten months from the previous survey date to avoid a lapse in accreditation. The re-survey may be conducted by one or more surveyors, and the survey fee is assessed at the prevailing fee. The re-survey will not necessarily be limited to the deficiencies noted in the previous survey report. The organization is required to submit an *Update for Re-survey* (the *Update for Re-survey* is available on the AAAHC Web site at *www.aaahc.org.*); however, an additional application fee is not required.

Please note that a maximum term of one year applies to organizations that are owned by a solo physician and: (1) either the organization or the solo physician is the subject of a governmental investigation or criminal indictment (other than a traffic violation); or (2) the physician's medical license is on probationary status. Such organizations should submit the application and application fee for a reaccreditation survey six months prior to the expiration of the original accreditation, in order to avoid a lapse in accreditation. A reaccreditation survey will be conducted. The survey fee is assessed at the prevailing rate.

All organizations that are currently accredited must advise the AAAHC within 30 days (as stated in Standard 2-I-C-3 and "Maintaining Accreditation" on pages 10 and 11) of any significant organizational, operational or financial changes, including changes in medical license status or any governmental investigation, criminal indictment or guilty plea or verdict in a criminal proceeding. From the time of this change in status, governmental investigation or criminal indictment, the term of the solo physician organization's accreditation will become one year or until the end of the current term of accreditation, whichever is less.

Six Months

The AAAHC awards a six-month term of accreditation when it concludes that the organization is in substantial compliance with the standards, but it is not eligible for a three-year term of accreditation because the organization does not meet certain requirements (*e.g.*, the organization has not been operational for six months). The AAAHC also awards a six-month term of accreditation to organizations that are in compliance with the standards, but the organization's demonstration of continued compliance with the standards is not sufficiently well established to grant a longer term of accreditation. The organization must have a re-survey within six months from the previous survey date to avoid a lapse in accreditation. Such a re-survey may be conducted by one or more surveyors in a visit to the organization. The survey fee is assessed at the prevailing rate. The re-survey is not necessarily limited to the deficiencies noted in the previous survey report. An additional application fee is not required.

Deferred Accreditation Decision

The AAAHC may defer an accreditation decision when the organization's operations do not meet the standards, but the organization demonstrates the commitment and capability to correct identified deficiencies within six months.

If an organization was not accredited prior to the deferred decision, the organization will remain not accredited. The organization must request a re-survey within three months of being notified of the deferred accreditation decision.

If an organization was accredited prior to the deferred decision and requests a re-survey within three months of being notified of the deferred accreditation decision, the organization remains accredited pending the decision on the findings of the re-survey.

Right of Reconsideration

A decision by the AAAHC for a one-year or six-month term of accreditation (excluding organizations undergoing Early Option Surveys) or a deferred decision may allow for the right of reconsideration by following the procedures outlined in Appendix C, Right of Reconsideration. No organization may request reconsideration at the same time that it requests another accreditation survey.

Denial or Revocation of Accreditation

The AAAHC denies accreditation to an organization when it concludes that the organization is not in substantial compliance with the AAAHC standards and/or policies or procedures. When the accreditation decision is based upon findings from an AAAHC survey, the decision is based on an organization's compliance at the time of the survey.

The AAAHC reserves the right to revoke or deny the accreditation of any organization at any time without prior notice if it determines that an organization: (1) no longer satisfies AAAHC Survey Eligibility Criteria; (2) is no longer in compliance with AAAHC policies, procedures or standards; (3) has significantly compromised or jeopardized patient care; (4) fails to act in good faith in providing data and other information to the AAAHC; (5) fails to notify the AAAHC within 30 days of any significant organizational, operational or financial change, or any change in ownership or control; or (6) fails to notify the AAAHC within 30 days of any imposition of sanctions, changes in license or qualification status, governmental investigation, criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) or any violation of state or federal law with respect to the organization, its owners, or its health care professionals.

In addition, the AAAHC may revoke or reduce the term of accreditation of an organization when it determines that there is a material change in the organizational structure, financial viability, operations, ownership or control of the organization or its ability to perform services which requires a new survey by the AAAHC to determine the organization's compliance with the AAAHC Survey Eligibility Criteria or the AAAHC standards. Revocation may be retroactive to the date of the material change, the imposition of sanctions or the violation of law.

An organization that is not granted accreditation or that has its accreditation revoked may apply for another survey at any time following the decision, as long as it has not exercised its right to appeal. An organization receiving a denial of accreditation or having its accreditation revoked must submit an *Application for Survey* and application fee when applying for another survey.

Appeal of Accreditation Decision

A decision of denial or revocation of accreditation by the Accreditation Committee, as approved by the Executive Committee, generally may be appealed. The appeal of any decision is governed by the AAAHC's appeal procedures which are in effect at the time of the appeal. Refer to Appendix B, Right of Appeal -Denial or Revocation of Accreditation.

In the unlikely event that the applicant has any controversy or claim with the AAAHC arising out of any procedures or decisions with respect to accreditation, the applicant shall have the right to reconsideration or appeal of such decision in accordance with the AAAHC's appeal procedures in effect at the time of such appeal. In the case of an appeal, upon final decision by the Board of Directors of the AAAHC, the applicant shall have the right to submit such decision for settlement by arbitration administered by the American Arbitration Association in Chicago, IL in accordance with its Commercial Arbitration Rules. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

Limitations on Other Rights

The applicant waives all other rights to sue or to resolution of any such claims against the AAAHC, its officers, directors, employees, agents, surveyors and members of its committees in a court of law.

The applicant recognizes and agrees that it shall not be entitled to monetary damages, whether compensatory, consequential, collateral, punitive or otherwise, from the AAAHC, its officers, directors, employees, agents, surveyors or members of its committees as a result of any controversy or claim with the AAAHC arising out of any procedures or decision with respect to accreditation.

Maintaining Accreditation

Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. The AAAHC reserves the right to amend its standards and policies so long as it provides all accredited organizations with notice of such amendments, or includes such amendments in the most recent edition of this *Handbook*.

In order to avoid a lapse in accreditation status, organizations must undergo full, regular surveys at least once every three years. Organizations must complete an *Application for Survey* for their subsequent full accreditation survey (referred to as a Reaccreditation Survey). Upon receipt of the application, the AAAHC will contact organizations to establish survey dates. To prevent a lapse in accreditation, reaccreditation surveys must occur within two months of the accreditation expiration date. Therefore it is required that

all documentation be submitted to the AAAHC at least five months prior to expiration dates. In states where accreditation is mandated by law, organizations should submit the required documentation a minimum of six months prior to their accreditation expiration date.

Accredited organizations must notify the AAAHC in writing within 30 days of any significant organizational, operational or financial changes including, but not limited to, mergers, change in majority interest, consolidation, name change, additional services or locations, death or incapacitation of the physician or dentist in solo physician or dentist organizations, changes in state license or federal certification or qualifying status, significant changes in managed care enrollment, significant changes in a managed care organization or staff membership, bankruptcy or other significant change in the financial viability of the organization, or any governmental investigation, criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the organization or any of its officers, administrators, physicians/practitioners or staff. An organization's duty to provide this information continues during the entire accreditation term. Failure to notify the AAAHC may result in an immediate revocation of accreditation or reduction in the term of accreditation. Depending on the circumstances, any significant organizational, operational or financial change may result in revocation of accreditation or reduction in the term of accreditation.

Transfer of Accreditation

Accreditation is not automatically transferable when an accredited organization changes ownership or control, as a result of a change such as a merger or consolidation. The accredited organization must advise the AAAHC within 30 days of any such change, as required by Standard 2-I-C-3 and "Maintaining Accreditation" on pages 10-11, and the AAAHC will determine whether the accreditation term is transferable and establish the conditions of transfer. Failure to comply with these provisions will result in the loss of accreditation.

Public Recognition

AAAHC - accredited organizations are encouraged to publicly display the Certificate of Accreditation provided by the AAAHC. Please note that the AAAHC certificate will reflect the legal name of the organization, as well as an additional name (*i.e.,* "dba"). All certificates remain the property of the AAAHC and must be returned if the organization is issued a new certificate reflecting a change in name or services for which it is accredited, or if it loses its accreditation for any cause.

The AAAHC publishes the list of organizations that have been awarded accreditation on its Web site *www.aaahc.org*, making no distinction between three-year, one-year and six-month terms of accreditation.

Confidentiality

The AAAHC will maintain as confidential all information provided to it with respect to any organization that is seeking or has obtained accreditation, will use such information solely for purposes of reaching an accreditation decision and will not disclose such information to any third party except (i) on prior written authorization from the organization; (ii) as otherwise provided in the *Handbook;* or (iii) as otherwise required by law.*

Except as indicated above, the contents of the survey report are provided only to the surveyed organization, which can disseminate it solely at its discretion.

In submitting its *Application for Survey*, the organization either provides or authorizes the AAAHC to obtain required official records and reports of public or publicly recognized licensing, examining, reviewing or planning bodies.

In the event that the AAAHC determines that an organization has supplied it with false, misleading or incomplete information, the AAAHC reserves the right to disclose any information about the organization to obtain accurate or complete information about the organization.

Medicare Deemed Status for AAAHC Accreditation of Ambulatory Surgery Centers (ASCs)

In December 2002, the AAAHC was granted a renewal of its deemed status for Medicare by the Centers for Medicare & Medicaid Services (CMS). To participate in the AAAHC/Medicare deemed status program, ASCs must be in compliance with the Medicare conditions for coverage as evidenced through an on-site combined AAAHC/Medicare deemed status survey. An AAAHC/Medicare deemed status survey is performed using AAAHC standards, as well as the Medicare requirements identified in certain chapters

* For example, the AAAHC is required to provide relevant survey information to the administrator of the Centers for Medicare & Medicaid Services (CMS) as part of the AAAHC/Medicare deemed status accreditation process.

in the *Handbook,* specifically, at the ends of Chapter 2, Governance; Chapter 8, Facilities and Environment; Chapter 9, Anesthesia Services; Chapter 10, Surgical and Related Services; Chapter 15, Pharmaceutical Services; and Chapter 17, Diagnostic and Other Imaging Services.

An important component of the Medicare certification process for an ASC is determining that the ASC is compliant with the *NFPA 101® Life Safety Code®, 2000 Edition* (LSC), which CMS adopted effective March 11, 2003. In addition, for a facility to operate as a Medicare certified facility, the New Ambulatory Health Care Occupancy Chapter 20, or the Existing Ambulatory Health Care Occupancy Chapter 21, of the LSC shall apply, regardless of the number of patients served. The ASC cannot be considered a Business Occupancy for purposes of determining LSC compliance.

To determine that the ASC meets the requirements of the LSC, when the organization requests a combined AAAHC/Medicare deemed status survey, the organization must submit a completed copy of the AAAHC *Physical Environment Checklist* that is based on the LSC. The *Checklist* is available for purchase from the AAAHC office or the AAAHC Web site, *www.aaahc.org.* The *Checklist* provides a format for schematic review of the fire and life safety issues involved with surgical facilities desiring certification by the Centers for Medicare & Medicaid Services (CMS) as an Ambulatory Surgery Center (ASC). It is based on the requirements of applicable National Fire Protection Association (NFPA) codes and standards, as referenced from the NFPA 101® LSC, 2000 Edition. The procedure for the proper application and completion of the *Checklist* is included with the *Checklist.*

The applying organization is responsible for assessing whether it meets the LSC requirements. The organization is required to complete the *Checklist,* maintain the original, and submit a copy to the AAAHC along with the *Application for Survey.* The AAAHC survey team is provided a copy of the *Checklist* prior to the on-site survey.

In addition to the added requirements noted above, ambulatory surgery centers requesting AAAHC/Medicare deemed status surveys should note that such surveys are conducted on an unannounced basis, and the names of the surveyor(s) are not disclosed to the organization prior to the survey.

Multisatellite Organizations Seeking an AAAHC/Medicare Deemed Status Survey

If an AAAHC/Medicare deemed status survey is sought for multiple locations, note that locations with unique Medicare provider numbers must apply for and be surveyed separately as independent organizations.

Types of AAAHC/Medicare Deemed Status Surveys

Initial AAAHC/Medicare Deemed Status Survey

A survey of an organization that is seeking AAAHC accreditation **for the first time.** The organization may or may not be currently Medicare certified.

Reaccreditation Medicare Survey

A survey of an organization that is currently AAAHC accredited and is seeking reaccreditation following a three-year term. The organization may or may not be currently Medicare certified.

Resurvey Medicare

A survey of an organization that may or may not be AAAHC accredited following a previous AAAHC/Medicare deemed status survey that resulted in one of the following decisions: one-year term, six-month term or six-month deferral.

Random Surveys

Refer to page 7.

Discretionary Surveys

Refer to page 7.

If AAAHC conducts a random or discretionary survey and the organization is judged not to be in substantial compliance with the standards, its accreditation will be revoked or reduced. (Refer to Denial or Revocation of Accreditation, page 10.)

Life Safety Code Survey

The AAAHC can conduct a Life Safety Code survey for organizations seeking an AAAHC/Medicare deemed status survey, but are unable to provide documented compliance with the *NFPA 101® Life Safety Code®, 2000 Edition.* The survey will be conducted at the prevailing rate.

New Facility Medicare/Early Option Survey with Medicare Program

The Early Option Survey (EOS) program is for organizations that: (1) that require accreditation for the purposes of state regulations that demand some form of accreditation before the facility can legally begin operations; and (2) are newly constructed and operational and require accreditation for health insurance, Medicare, managed care, or other third-party reimbursement, and a six-month wait would entail financial hardship.

The eligibility criteria for an organization to participate in the EOS program are the same as the regular AAAHC eligibility criteria, except that the requirement that an organization has been providing health care services for at least six months before the on-site survey is conducted is waived when the factors described above are present and when the organization requests such waiver.

When a New Facility Medicare Survey (EOS with Medicare) is scheduled for purposes of obtaining or maintaining Medicare certification, the organization must provide evidence of the following with its *Application for Survey:*

- that licensure or provisional licensure has been obtained from the state in which the organization operates (if the organization is not subject to a facility licensure law in its state, then it should provide a statement from the state agency attesting to this fact. If an organization's state requires a licensure survey just prior to opening for preliminary licensure, verification of the preliminary license or survey may be obtained by the survey team at the time of the EOS);
- the building in which patient care services will be delivered is built and ready to support patient care service delivery;
- all policies and procedures, bylaws, governance and administrative structures are in place;
- key executive and medical staff have been employed by the organization;
- all necessary equipment is in place and has been appropriately tested and/or calibrated with up-to-date maintenance logs in place;
- the opening date has been identified;
- an ASC license;
- documented full compliance with the *NFPA 101® Life Safety Code®, 2000 Edition*, by completion of the AAAHC *Physical Environment Checklist;*
- a non-denial statement (page 7 of the *Application for Survey*) completed and signed by an authorized person at the organization.

A New Facility Medicare Survey will be conducted on an unannounced basis after the center has opened. The names of the surveyor(s) are not disclosed to the organization prior to the survey. A minimum of one procedure must have been completed prior to the survey.

AAAHC awards an ASC a six-month term of accreditation when it concludes that the organization meets the Medicare conditions for coverage and is in compliance with the AAAHC standards, but is not eligible for a three-year term of accreditation because the ASC has not been operational for six months. The ASC must have a re-survey within five months from the previous survey date with a focus on the issue of sustained performance since the initial survey. Such a re-survey may be conducted by one or more surveyors in a survey of the ASC at the prevailing fee. The re-survey is not limited to the deficiencies in the previous survey report. An additional application fee is not required.

The AAAHC may also award a one-year term of accreditation. For details, please see "One Year" on page 14.

If an organization requests an AAAHC/Medicare deemed status survey following an Early Option Survey, or following a regular accreditation survey, the organization is required to submit a new application. An application fee is not charged if the requested AAAHC/Medicare deemed status survey is the re-survey following an Early Option Survey. However, if the requested AAAHC/Medicare deemed status survey follows an initial or reaccreditation survey, an application fee is charged.

Terms of Accreditation for AAAHC/Medicare Deemed Status Surveys

For ASCs that undergo an AAAHC/Medicare deemed status survey, the following terms of accreditation may be awarded:

Three Years

The AAAHC awards an ASC accreditation for three years when it concludes that the ASC is in compliance not only with the AAAHC standards, but also with the Medicare

conditions for coverage. A three-year term also indicates that the AAAHC has no reservations about the accuracy of the survey findings or the ASC's commitment to continue providing high-quality care and services consistent with AAAHC standards.

One Year

The AAAHC awards an ASC accreditation for one year when it concludes that the ASC meets the Medicare conditions for coverage. However, a portion of the ASC's operations require sufficient time to achieve and sustain compliance with all AAAHC standards.

The organization must have a re-survey within ten months from the previous survey date to avoid a lapse in accreditation. Such a re-survey may be conducted by one or more surveyors in a survey of the ASC at the prevailing fee. The on-site review is not limited to the deficiencies noted in the previous survey report. The organization is required to submit an *Update for Re-survey* (the *Update for Re-survey* is available on the AAAHC Web site at *www.aaahc.org*), but an additional application fee is not required.

Six Months

The AAAHC awards a six-month term of accreditation to an ASC that has been in business for greater than six months, is seeking both AAAHC accreditation and Medicare certification for the first time, meets the Medicare conditions for coverage and is in compliance with the AAAHC standards. The ASC must have a re-survey within five months from the previous survey date with a focus on the issue of sustained performance since the previous survey. Such a re-survey may be conducted by one or more surveyors in a survey of the ASC at the prevailing fee. The re-survey is not limited to the deficiencies noted in the previous survey report. An additional application fee is not required.

Deferred Accreditation Decision

The AAAHC may defer an accreditation decision when the ASC's operations do not meet the AAAHC standards or the Medicare conditions for coverage, but the organization demonstrates the commitment and capability to correct identified deficiencies within six months.

When the AAAHC defers an accreditation decision, the ASC is no longer eligible to participate in the AAAHC/Medicare deemed status program until all Medicare deficiencies are addressed.

In such cases, the organization must contact the AAAHC to request another re-survey. The request must be made within three months of being notified of the deferred accreditation decision, and the re-survey must occur within six months of the date of the previous survey. This survey will be conducted at the prevailing rate; however, no additional application fee will be assessed.

If an organization was not accredited prior to the deferred decision, the organization will remain not accredited. If an organization was accredited prior to the deferred decision and requests a re-survey within three months of being notified of the deferred accreditation decision, the organization remains accredited pending the decision on the findings of the re-survey.

Denial of Accreditation Following an AAAHC/Medicare Deemed Status Survey

The AAAHC denies accreditation to an ASC when it concludes that the ASC is not in compliance with the Medicare conditions for coverage and/or the AAAHC standards. When the AAAHC denies accreditation, the ASC is not eligible, or is no longer eligible, to participate in the AAAHC/Medicare deemed status program and is subject to further review by the appropriate state agency.

AAAHC/Medicare Deemed Status for Medicare Advantage

The Balanced Budget Act of 1997 (BBA), as amended by the Balanced Budget Refinement Act of 1999 (BBRA) gave the Centers for Medicare & Medicaid Services (CMS) the authority to establish and oversee a program that allows private, national accreditation organizations to "deem" that a Medicare Advantage organization is in compliance with certain Medicare requirements. In July 2006, the CMS announced the re-approval of the AAAHC for "deemed status" for Medicare Advantage. This authority applies to both HMOs and PPOs that are accredited by the AAAHC.

The six areas under the Medicare Advantage deeming authority are: quality assurance, anti-discrimination, access to services, confidentiality and accuracy of enrollee records, information on advance directives, and provider participation rules.

A managed care organization that participates in the Medicare Advantage program may choose to have its AAAHC survey include a review of the Medicare Advantage requirements that have been approved under

the CMS deemed status program. Medicare Advantage organizations that request such a survey should obtain the AAAHC *Supplemental Medicare Advantage Guidebook* that contains the additional Medicare Advantage requirements the AAAHC surveyors will review for compliance.

California AB 595 Surveys

On July 1, 1996, AB 595 (Speier) became effective prohibiting any physician or surgeon from performing surgery in an outpatient surgery setting using specified anesthesia levels unless the setting is one of an enumerated care setting(s), including a setting accredited by an approved accrediting agency, state licensed as an outpatient services facility or Medicare certified as an ambulatory surgery center. Therefore, AB 595 required the Medical Board of California, Division of Licensing, to adopt standards for approval of accreditation agencies to perform the accreditation of outpatient surgery settings. The AAAHC has received approval from the Medical Board of California as a recognized accrediting agency. Therefore, organizations choosing to have their accreditation be reported to the Medical Board for evidence of compliance with the law must indicate such to the AAAHC during the time of the survey application process.

In addition to the AAAHC standards found in this *Handbook*, the organization must also be in compliance with the following requirements:

- the certificate of accreditation must be posted in a location readily visible to patients and staff;
- the name and telephone number of the accrediting agency with instructions on the submission of complaints must be posted in a location readily visible to patients and staff;
- written discharge criteria must exist;
- a minimum of two staff persons must be on the premises, one of whom shall be a licensed physician and surgeon and/or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer of a patient who does not meet the above required written discharge criteria to an unlicensed setting is not acceptable.

Definition and Construction of Certain Words and Phrases

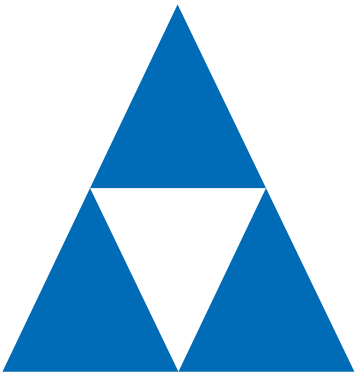
Whenever in these standards the word "state" is used, it is interpreted also to include any commonwealth, territory, or other territorial and insular possession of the United States. The word "state" shall also mean "province" or "provincial" in the context of a health care organization in Canada.

For organizations that operate in Canada, references to federal and/or state laws and regulations are interpreted to mean Canadian federal and/or provincial laws and regulations. In these cases, references to specific U.S. federal statutes, such as OSHA, ADA, HIPAA refer to equivalent or similar existing Canadian statutes.

There are occasional references to "medical" records, "medical" advice, or other uses of "medical" as an adjective (in most cases this has been for ease of communication). This use of the word "medical" is not intended to exclude dentistry, podiatry, optometry or chiropractic, and when the word "medical" appears alone it generally should be construed as meaning "clinical" and including services provided by dentists, podiatrists, optometrists and chiropractors, who are licensed in accordance with applicable state law.

Compliance with Omnibus Reconciliation Act of 1980

For any health care organization that pays the AAAHC $10,000 or more in any 12-month period to comply with Section 952, PL 96-499, the Omnibus Reconciliation Act of 1980, the AAAHC hereby stipulates that only those AAAHC records, contracts, documents or books that are necessary to verify the extent and nature of AAAHC costs will be available for four years after the survey, consultation or contracted services are completed to the Secretary of the Department of Health and Human Services (DHHS), the Comptroller General of the United States, or any of their duly authorized representatives. This stipulation is provided as a matter of policy by AAAHC in lieu of providing separate contracts for each affected organization. These same conditions will apply to any subcontracts the AAAHC has with related organizations if such payments amount to $10,000 or more in any 12-month period. This policy applies to all contracts, surveys, and AAAHC records as of December 5, 1980, and so long as these regulations remain in force.



Core Standards

The applicable portions of the core standards will be evaluated based on the services provided by the organization.

1 Rights of Patients

An accreditable organization recognizes the basic human rights of patients. Such an organization has the following characteristics.

A. Patients are treated with respect, consideration and dignity.

B. Patients are provided appropriate privacy.

C. Patient disclosures and records are treated confidentially, and, except when required by law, patients are given the opportunity to approve or refuse their release.

D. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

E. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

F. Information is available to patients and staff concerning:

1. patient rights, including those specified in A, B, C, D and E above
2. patient conduct and responsibilities
3. services available at the organization
4. provisions for after-hours and emergency care
5. fees for services
6. payment policies
7. patient's right to refuse to participate in experimental research
8. advance directives, as required by state or federal law and regulations
9. credentialing of health care professionals.

G. Patients are informed of their right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

H. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.

I. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.

J. Patients are informed about procedures for expressing suggestions to the organization and policies regarding grievance procedures and external appeals, as required by state and federal law and regulations.

2 Governance

An accreditable organization has a governing body that sets policy and is responsible for the organization. Such an organization has the following characteristics.

Subchapter I - General Requirements: This subchapter describes general requirements for an organization and its governing body.

A. The organization is a legally constituted entity, or an organized subunit of a legally constituted entity, in the state(s) in which it is located and provides services. A legally constituted entity is constituted by at least one of the following:

1. charter
2. articles of incorporation
3. partnership agreement
4. franchise agreement
5. legislative or executive act
6. or, is a sole proprietorship.

B. The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to:

1. determining the mission, goals and objectives of the organization
2. ensuring that facilities and personnel are adequate and appropriate to carry out the mission
3. establishing an organizational structure and specifying functional relationships among the various components of the organization
4. adopting bylaws or similar rules and regulations for the orderly development and management of the organization
5. adopting policies and procedures necessary for the orderly conduct of the organization, including the organization's scope of clinical activities
   a. the organization develops and maintains a policy defining the care of pediatric patients, if relevant. Specific components of peri-operative care are listed in Standard 10-V.
6. assuring that the quality of care is evaluated and that identified problems are appropriately addressed
7. reviewing all legal and ethical matters concerning the organization and its staff and, when necessary, responding appropriately
8. maintaining effective communication throughout the organization, including ensuring a linkage between quality management and improvement activities and other management functions of the organization
9. establishing a system of financial management and accountability appropriate to the organization
10. determining a policy on the rights of patients
11. approving and ensuring compliance of all major contracts or arrangements affecting the medical and dental care provided under its auspices including, but not limited to, those concerning:
    a. the employment or contracting of health care professionals
    b. the provision of radiology services and pathology and medical laboratory services
    c. the use of external laboratories
    d. the provision of care by other health care organizations, such as hospitals
    e. the provision of education to students and postgraduate trainees
    f. the provision of after-hours patient information or telephone triage services, including the review of protocols

g. the Centers for Medicare & Medicaid Services (CMS) requirements, if the organization participates in the Medicare/ Medicaid program

h. the policies/procedures related to utilization, quality improvement, risk management, credentialing, patients rights, etc., of a managed care organization, if the organization/provider has contracts with managed care organizations

i. the activities or services delegated to another entity.

12. formulating long-range plans in accordance with the mission, goals and objectives of the organization

13. operating the organization without violating federal or state anti-discrimination laws

14. ensuring that all marketing and advertising concerning the organization does not imply that it provides care or services that it is not capable of providing

15. developing a program of risk management appropriate to the organization

16. determining a policy on continuing education for personnel and/or patient education for members/enrollees, if applicable

17. developing policies that comply with all applicable occupational health and safety regulations for health care workers such as the Occupational Safety and Health Administration (OSHA) rules on Occupational Exposure to Bloodborne Pathogens (CFR Part 1910.1030)

18. establishing a mechanism to fulfill all applicable obligations under local, state and federal laws and regulations such as those addressing disabilities, medical privacy, fraud and abuse, self-referral and the National Practitioner Data Bank[1]

19. operating the organization's facilities and environment in a safe manner

20. adopting policies/procedures to resolve grievances and external appeals, as required by state and federal law and regulations

21. confirming that any entities or facilities that contract with a managed care organization for services have been approved by a recognized accrediting body, or that the governing body has developed and implemented standards of participation for the entity

22. establishing processes for the identification, reporting, analysis and prevention of adverse incidents and ensuring their consistent and effective implementation by developing a system that includes:

    a. definition of an adverse incident that, at a minimum, includes:

        i. an unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition

        ii. any process variation for which a recurrence carries a significant chance of a serious adverse outcome

[1] For information on the National Practitioner Data Bank, see *http://www.npdb-hipdb.com*.

iii. events such as breaches in medical care, administrative procedures or other breaches resulting in a negative impact on a patient, even where death or loss of limb or function does not occur.

b. a process for conducting a thorough analysis when an adverse incident occurs in order to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an adverse incident. The analysis identifies potential improvements in processes or systems that would tend to decrease the likelihood of such incidents in the future, or determines, after analysis, that no such improvement opportunities exist.

c. a process for reporting adverse incidents through established channels within the organization and, as appropriate, to external agencies in accordance with law and regulation.

d. an action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar incidents occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

C. The governing body provides for full disclosure of ownership and significant organizational, operational and financial changes.

1. The names and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies or subdivisions of other bodies, such as public agencies or religious, fraternal, or other philanthropic organizations) are furnished to the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

2. For corporations, the names and addresses of all officers, directors and principal stockholders, either beneficial or of record, are available to the public upon request and are furnished to the AAAHC.

3. Accredited organizations must notify the AAAHC within 30 days of any significant organizational, operational or financial changes including but not limited to mergers, change in majority interest, consolidation, name change, additional services or locations, death or incapacitation of physician or dentist in solo physician or dental organizations, changes in state license or federal certification or qualifying status, significant change in managed care enrollment, significant changes in a managed care organization or staff membership, bankruptcy, or other significant change in the financial viability of the organization, or any government investigation, criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the organization or any of its officers, administrators, physicians/practitioners or staff. An organization's duty to provide this information continues during the entire accreditation term.

D. The governing body meets at least annually and keeps such minutes or other records as may be necessary for the orderly conduct of the organization.

1. Items to be reviewed should include, but are not limited to:

   a. rights of patients

   b. delegated administrative responsibilities

   c. quality of care

   d. the quality management and improvement program, policies and procedures, including the credentialing and privileging of health care professionals

   e. compliance to all other applicable standards.

E. If the governing body elects, appoints or employs officers and administrators to carry out its directives, the authority, responsibility and functions of all such positions are defined.

Subchapter II - Credentialing and Privileging:
This subchapter describes the requirements for credentialing and privileging of health care professionals to provide patient care in an accreditable organization.

Credentialing is a three-phase process of assessing and validating the qualifications of an individual to provide services. The objective of credentialing is to establish that the applicant has the specialized professional background that he or she claims and that the position requires. An accreditable organization: 1) establishes minimum training, experience and other requirements (*i.e.*, credentials) for physicians and other health care professionals; 2) establishes a process to review, assess and validate an individual's qualifications, including education, training, experience, certification, licensure and any other competence-enhancing activities against the organization's established minimum requirements; and 3) carries out the review, assessment and validation as outlined in the organization's description of the process.

A. The governing body establishes and is responsible for a credentialing and reappointment process, applying criteria in a uniform manner to appoint individuals to provide patient care for the organization. The governing body approves mechanisms for credentialing, reappointment and the granting of privileges, and suspending or terminating clinical privileges, including provisions for appeal of such decisions.

B. The governing body, either directly or by delegation, makes (in a manner consistent with state law) initial appointment, reappointment and assignment or curtailment of clinical privileges based on professional peer evaluation. This process shall have the following characteristics:

1. The governing body has specific criteria for the initial appointment and reappointment of physicians and dentists.

2. Provisions are made for the expeditious processing of applications for clinical privileges.

3. On an application for initial credentialing and privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested. At a minimum, the following credentialing and privileging information shall be provided for evaluation of the candidate:

    a. education, training and experience. Relevant education and training are verified at the time of appointment and initial granting of clinical privileges. The applicant's experience is reviewed for continuity, relevance and documentation of any interruptions in that experience.

    b. peer evaluation. Current competence is verified in writing by individuals personally familiar with the applicant's clinical, professional and ethical performance and when available, by data based on analysis of treatment outcomes.

    c. current state license. Current licensure is verified and documented at the time of appointment.

    d. Drug Enforcement Administration (DEA) registration, if applicable

    e. proof of current medical liability coverage meeting governing body requirements, if any

    f. information obtained from the National Practitioner Data Bank[1]

    g. the organization shall require and review other pertinent information which includes, but need not be limited to:

        i. professional liability claims history

        ii. information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations

        iii. complaints or adverse action reports filed against the applicant with a local, state, or national professional society or licensure board

        iv. refusal or cancellation of professional liability coverage

        v. denial, suspension, limitation, termination or nonrenewal of professional privileges at any clinic, hospital, health plan or other institution

        vi. DEA and state license action

        vii. disclosure of any Medicare/Medicaid sanctions

        viii. conviction of a criminal offense (other than minor traffic violations)

        ix. current physical, mental health, or chemical dependency problems that would interfere with an applicant's ability to provide high-quality patient care and professional services

        x. signed statement releasing the organization from liability and attesting to the correctness and completeness of the submitted information.

4. Upon completion of the application, the credentials are verified according to procedures established in the bylaws, rules and regulations. The organization has established procedures to obtain information necessary for primary or secondary source verification of the application and is responsible for obtaining this information. An accreditable organization may use information provided by a Credentials Verification Organization (CVO) after proper assessment of the capability and quality of

the CVO. Accreditation or certification of the CVO by AAAHC or another nationally recognized accreditation organization is one way of demonstrating such capability and quality. Primary or acceptable secondary source verification is required for licensure, education, training and experience, unless a CVO, or an organization performing primary source verification that is accredited or certified by a nationally recognized body is used. Where the organization utilizes a CVO or another organization to verify credentials, those entities must perform primary source verification unless such sources do not exist or are impossible to verify. Appendix L describes and contains examples of primary and acceptable sources of secondary source verification.

5. Applicants shall apply for reappointment at least every three years, unless state law provides otherwise. On an application for reappointment, the organization verifies current licensure, information obtained from the National Practitioner Data Bank[1], DEA registration, if applicable, and reviews status of any board certifications and other pertinent information which includes, but need not be limited to, items listed in Standard 2-II-B-3 (g) and peer review activities as described in Subchapter I of Chapter 5.

6. The organization shall monitor and document current licensure, professional liability insurance if required, certifications, DEA and other registrations, where applicable, on an ongoing basis.

7. Credentials files are maintained for each health care professional to include the initial application, reapplication, verifications, privileges granted and other pertinent information as required by the organization.

8. In a solo physician practice, the physician's credentials file shall be reviewed by a peer at least every three years, unless state law provides otherwise, to assure currency, accuracy and completeness. The physician is required to complete an application or reapplication, and the documentation identified in Standard 2-II-B-3 must be present in the credentials file, including a list of procedures that will be performed by the physician in the organization and evidence of appropriate education, training and experience to perform the privileges/procedures. Applications are available for other physicians requesting credentialing and privileges to perform procedures in the solo physician's organization, including any anesthesia providers. In a solo physician practice, the granting of privileges shall be reviewed by a peer.

Privileging is a three-phase process. The objective of privileging is to determine the specific procedures and treatments that a health care professional may perform. An accreditable organization: 1) determines the clinical procedures and treatments that are offered to patients; 2) determines the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege; and 3) establishes a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying or denying any or all of the requested privileges in a non-arbitrary manner.

C. Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specified period of time. These privileges are granted based on an applicant's qualifications within the services provided by the organization. Privileges may be added pursuant to the organization's policies and procedures.

D. Mechanisms are in place for the organization to notify licensing and/or disciplinary bodies or other appropriate authorities when a health care professional's privileges are suspended or terminated, as required by state or federal law and regulations.

E. The organization has its own independent process of credentialing and privileging. The approval of credentials or the granting of privileges requires review and approval by the organization's governing body. Credentials may not be approved, nor privileges granted, solely on the basis that another organization, such as a hospital, approved credentials or granted privileges, without further review. Such status at another organization may be included in the governing body's consideration of the application.

F. The governing body provides a process (in a manner consistent with state law and based on evidence of education, training, experience, and current competence) for the initial appointment, reappointment and assignment or curtailment of privileges and practice for allied health care professionals.

Additional Medicare Requirements

Medicare requirements will be applied by the AAAHC in surveys when an ambulatory surgery center elects to have an AAAHC/Medicare deemed status survey, which may be recognized for purposes of Medicare certification.

I-A-MS. When applicable, the ASC must comply with state licensure requirements.

I-B-MS. The medical staff of the ASC must be accountable to the governing body.

3 Administration

An accreditable organization is administered in a manner that assures the provision of high-quality health services and that fulfills the organization's mission, goals and objectives. Such an organization has the following characteristics.

A. Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to:

1. enforcing policies delegated by the governing body
2. employing qualified management personnel
3. long-range and short-range planning for the needs of the organization, as determined by the governing body
4. taking all reasonable steps to comply with applicable laws and regulations
5. protecting the assets of the organization
6. implementing fiscal controls, including, but not limited to:
    a. authorization and record procedures that are adequate to provide accounting controls over assets, liabilities, revenues and expenses
    b. policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements
    c. rates and charges for services provided by the organization
    d. methods of collection of unpaid accounts that are reviewed before referral to a collection agency.
7. using methods of communicating and reporting designed to ensure the orderly flow of information within the organization
8. controlling the purchase, maintenance and distribution of the equipment, materials and facilities of the organization
9. establishing lines of authority, accountability and supervision of personnel
10. establishing controls relating to the custody of the official documents of the organization
11. maintaining the confidentiality, security and physical safety of data on patients and staff
12. maintaining a health information system that collects, integrates, analyzes and reports data as necessary to meet the needs of the organization
    a. Characteristics of the system should include, but are not limited to:
        i. meeting performance improvement/ study needs
        ii. maintaining appropriate data on patient/ enrollees, health care professionals and services provided to patient members, if the organization is a managed care organization
        iii. ensuring accurate, timely and complete data in a consistent manner as appropriate for the organization
        iv. maintaining collected data in a standardized format to the extent feasible and appropriate.
13. addressing the relationships with competing health care organizations so as to avoid antitrust and restraint of trade concerns
14. dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters and the media
15. documentation of adequate orientation and training to familiarize all personnel with the organization's policies, procedures and facilities.

B. Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies:

1. define and delineate functional responsibilities and authority
2. require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification
3. require periodic appraisal of each person's job performance, including current competence
4. describe incentives and rewards, if any exist
5. require periodic review of employee compensation
6. specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system, as described in Standard 2-I-B-22
7. are made known to employees at the time of employment
8. comply with federal and state laws and regulations regarding the protection of the health of employees and provide for appropriate occupational health services for those employees.

C. The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body and when appropriate, corrective actions are taken.

D. When students and postgraduate trainees are present, their status is defined in the organization's personnel policies.

4 Quality of Care Provided

An accreditable organization provides high-quality health care services in accordance with the principles of professional practice and ethical conduct, and with concern for the costs of care and for improving the community's health status. Such an organization has the following characteristics.

A. All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.

B. Health care professionals practice their professions in an ethical and legal manner.

C. All personnel assisting in the provision of health care services are appropriately trained, qualified and supervised and are available in sufficient numbers for the care provided.

D. The provision of high-quality health care services is demonstrated by at least the following:

1. education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures and use of the health care system
2. accessible and available health services
3. appropriate and timely diagnosis based on findings of the initial assessment (history and physical examination)
4. treatment that is consistent with clinical impression or working diagnosis
5. appropriate and timely consultation
6. absence of clinically unnecessary diagnostic or therapeutic procedures
7. appropriate and timely referrals
8. appropriate and timely follow-up of findings and tests
9. patient cooperation
10. continuity of care
11. provision for services when the organization's facilities are not open
12. adequate and timely transfer of information when patients are transferred to other health care professionals
13. patient satisfaction
14. an increased likelihood of desired health outcomes through participation in performance measurement and quality improvement activities
15. health services provided are consistent with current professional knowledge
16. an adverse incident reporting system, as described in Standard 2-I-B-22
17. a mechanism to notify public health authorities of reportable conditions.

E. The organization maintains appropriate, accurate and complete clinical record entries.

F. The organization establishes procedures to obtain, identify, store and transport laboratory specimens.

G. When clinically indicated, patients are contacted as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings that have been identified.

H. When the need arises, patients are transferred from the care of one health care professional to another.

1. Adequate specialty consultation services are available by prior arrangement.
2. Referral to a health care professional is clearly outlined to the patient and arranged with the accepting health care professional prior to transfer.

I. Concern for the costs of care is demonstrated by the following:

1. the relevance of health care services to the needs of the patients
2. the absence of duplicative diagnostic procedures
3. the appropriateness of treatment frequency
4. the use of the least expensive alternate resources when suitable
5. the use of ancillary services that are consistent with patients' needs.

J. When the need arises, reasonable attempts are made for health care professionals and other staff to communicate with patients in the language or manner primarily used by them.

K. As appropriate, the organization participates in community health emergency or disaster preparedness.

5 Quality Management and Improvement

In striving to improve the quality of care and to promote more effective and efficient utilization of facilities and services, an accreditable organization maintains an active, integrated, organized, peer-based program of quality management and improvement that links peer review, quality improvement activities and risk management in an organized, systematic way. Such an organization has the following characteristics.

Subchapter I - Peer Review: An accreditable organization maintains an active and organized process for peer review that is integrated into the quality management and improvement program and is evidenced by the following characteristics:

A. The health care professionals[1] understand, support and participate in a peer review program through organized mechanisms and are responsible to the governing body. The peer review activities are evidenced in the quality improvement program.

B. At least two (2) physicians (or dentists in dental practices) are involved to provide peer-based review. (In solo physician or dental organizations, such as office-based surgical practices, independent practice associations and dental practices, an outside physician or dentist is involved to provide peer-based review.)

1. At least two (2) health care professionals, one of whom may be a physician or dentist, are involved to provide peer-based review within their scope of practice for professionals such as nurse practitioners, certified registered nurse anesthetists and physician assistants. Peer review as part of an employee's performance evaluation is acceptable.

2. Peer review is consistent with the organization's policies and procedures and is evidenced in the quality improvement program.

3. The organization provides ongoing monitoring of important aspects of the care provided by physicians, dentists and other health care professionals. Monitoring important aspects of care by individual practitioners, as well as practitioners in the aggregate, is necessary for monitoring individual performance and establishing internal benchmarks.[2]

C. Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.

D. Data related to established criteria are collected in an ongoing manner and are periodically evaluated to identify acceptable or unacceptable trends or occurrences that affect patient outcomes.

E. The results of peer review activities are reported to the governing body.

F. The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in Subchapter II of Chapter 2.

G. To improve the professional competence and skill, as well as the quality of performance, of the health care professionals and other professional personnel it employs, the organization:

1. provides convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative and research services provided by the organization

[1] As used in this chapter, the term "health care professionals" includes all clinical and administrative personnel.

[2] **Benchmarking**: A systematic comparison of products, services or work processes of similar organizations, departments or practitioners to identify best practices known to date for the purpose of continuous quality improvement.

External benchmarking compares performance between different organizations.

Internal benchmarking compares performance within an organization, such as by physician or department, or over time. For the purposes of accreditation, the internal benchmarking standard does not apply to organizations with fewer than three practitioners.

2. encourages health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures. These educational programs may be internal or external, and are consistent with the organization's mission, goals and objectives.

H. The organization provides a monitoring function to ensure the continued maintenance of licensure and/or certification of professional personnel who provide health care services at the organization.

Subchapter II - Quality Improvement Program:
An accreditable organization maintains an active, integrated, organized, peer-based quality improvement (QI) program as evidenced by the following characteristics:

A. The organization develops and implements a quality improvement program that is broad in scope to address clinical, administrative and cost-of-care performance issues, as well as actual patient outcomes, *i.e.*, results of care, including safety of patients. Characteristics of the program must include, but are not limited to:

1. a written description of the program that addresses the scope of the organization's health care delivery services and how the quality improvement plan for these services are assessed

2. identification of the specific committee(s) or individuals responsible for the development, implementation and oversight of the program

3. participation in the program by health care professionals, one or more of whom is a physician

4. quality improvement goals and objectives

5. development of processes to identify important problems or concerns that are appropriate to address for improving the quality of services provided by the organization

6. identification of quality improvement activities such as studies, including methods for benchmarking[2] performance, to support the goals of the program

7. defined linkages between quality improvement activities, peer review and the risk management program

8. evaluation of the overall effectiveness of the program at least annually

9. identification of processes to report findings from the quality improvement activities to the organization's governing body, and throughout the organization as appropriate.

B. The organization conducts specific quality improvement activities that support the goals of the QI program. Quality improvement activities must include, but are not limited to, the following characteristics:

1. the assessed purpose of the activity and the significance of the problem(s) or concern(s). Sources of identifiable problems may include but are not limited to:

   a. unacceptable or unexpected outcomes of ongoing monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, medication errors, specific misdiagnoses, near misses, etc.

   b. the clinical performance and practice patterns of health care professionals

   c. variances from expected performance identified through clinical record review of the quality of care, and completeness of entries and/or maintaining clinical record policies

d. variances from expected results identified by quality control processes, diagnostic imaging, pathology, medical laboratory and pharmaceutical services

e. other professional, technical and ancillary services provided

f. assessment of, and response to, patient satisfaction surveys

g. direct observation of processes and/or practices

h. staff concerns

i. access to care and/or timeliness of services

j. medical/legal issues

k. wasteful practices

l. overutilization or underutilization of services

m. prevention, screening, evaluation, treatment or management of prevalent diseases, including chronic conditions, behavioral health, etc., provided by the organization

n. testing new or enhanced processes or methods of care

o. benchmarking against best practices, professional practice guidelines and performance measures[3], or established health care goals

p. short or long-range planning goals.

2. identification of performance measures, goals and objectives

3. identification of data related to established criteria to evaluate and analyze the frequency, severity and source of suspected problems or concerns

4. implementation of corrective actions such as interventions to resolve important problems or concerns that have been identified

5. re-measurement of the problem to determine objectively whether the corrective actions have achieved and sustained demonstrable improvement

6. identification, analysis and implementation of additional corrective actions, if the problem remains, to achieve and sustain demonstrable improvement

7. communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").

C. The organization's quality improvement program must include participation in performance benchmarking activities that will allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals.

1. The organization's benchmarking activities may include, but are not limited to:

   a. the use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served

[3] **Performance Measure**: A clearly defined statement or question describing information to be collected for purposes of improving processes and outcomes of care.

b. systemically collecting and analyzing data related to the selected performance measures

c. ensuring the validity and reliability of data

d. measuring changes in performance related to the performance measures

e. demonstrating and sustaining performance improvement over time

f. using benchmarks that are based on local, state, or national standards, *i.e.*, performance measures.[3]

2. Results of benchmarking activities must be incorporated into other quality improvement activities of the organization.

3. Results of benchmarking activities must be reported to the organization's governing body and throughout the organization, as appropriate.

Subchapter III - Risk Management: An accreditable organization develops and maintains a program of risk management, appropriate to the organization, designed to protect the life and welfare of an organization's patients and employees. Such an organization has the following characteristics:

A. The governing body of the organization is responsible for overseeing the program of risk management that includes the elements listed in Standard 5-III-C, and as appropriate to the organization, the requirements described in Subchapter I of Chapter 2 and Chapter 3.

B. There is a person or committee responsible for the risk management program.

C. Elements of a risk management program address safety of patients and other important issues, which include:

1. consistent application of the risk management program throughout the organization, including all departments and all service locations

2. methods by which a patient may be dismissed from care or refused care

3. reporting, reviewing and appropriate analysis of all incidents reported by employees, patients, health care professionals and others

4. periodic review of all litigation involving the organization and its staff and health care professionals

5. review of all deaths, trauma, or other adverse incidents as defined in Chapter 2-I-B-22, including reactions to drugs and materials

6. review of patient complaints

7. communications with the professional liability insurance carrier

8. managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure
9. impaired health care professionals
10. establishment and documentation of coverage after normal working hours
11. methods for prevention of unauthorized prescribing
12. processes to identify and/or designate the surgical site and involve the patient in those processes.

D. The risk management program conducts a periodic review of clinical records and clinical record policies.

E. Education in risk management activities is provided to all staff and affiliated persons.

6 Clinical Records and Health Information

An accreditable organization maintains a clinical records and health information system from which information can be retrieved promptly. Clinical records are comprehensive, legible, documented accurately in a timely manner and readily accessible to health care professionals. Such an organization has the following characteristics.

A. The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval and distribution of patient records.

B. An individual clinical record is established for each person receiving care. Each record includes, but is not limited to:

1. name
2. identification number (if appropriate)
3. date of birth
4. gender
5. responsible party, if applicable.

C. All clinical information relevant to a patient is readily available to authorized health care practitioners any time the organization is open to patients.

D. Except when otherwise required by law, any record that contains clinical, social, financial or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

E. There is a person designated in charge of clinical records whose responsibilities include, but are not limited to:

1. the confidentiality, security and physical safety of records
2. the timely retrieval of individual records upon request
3. the unique identification of each patient's record
4. the supervision of the collection, processing, maintenance, storage, retrieval and distribution of records
5. the maintenance of a predetermined, organized and secured record format.

F. Policies concerning clinical records address, but are not limited to:

1. retention of active records
2. the retirement of inactive records
3. the timely entry of data in records
4. the release of information contained in records.

G. Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care. Any abbreviations and dose designations must be standardized according to a list approved by the organization.

H. Reports, histories and physicals, progress notes and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record in a timely manner.

I. If a patient's clinical record is complex and lengthy, a summary of past surgical procedures as well as past and current diagnoses or problems is documented in that patient's record to facilitate the ongoing provision of rational care.

J. The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and uniform location in all patient records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified.

K. Entries in a patient's record for each visit include, but are not limited to:

1. date, department (if departmentalized), and physician or other health care professional's name and profession (for example, PT, MD, RN and so forth)
2. chief complaint or purpose of visit
3. clinical findings
4. diagnosis or impression
5. studies ordered, such as laboratory or x-ray studies
6. care rendered and therapies administered
7. disposition, recommendations and instructions given to the patient
8. authentication and verification of contents by health care professionals
9. missed and canceled appointments should have follow-up documentation.

L. Significant medical advice given to a patient by telephone is entered in the patient's record and appropriately signed or initialed, including medical advice provided by after-hours telephone patient information or triage telephone services.

M. Entries in patient's clinical records are legible to the clinical personnel in the organization.

N. Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.

O. When necessary for ensuring continuity of care, summaries or records of a patient who was treated elsewhere (such as by another physician, hospital, ambulatory surgical service, nursing home or consultant) are obtained.

P. When necessary for ensuring continuity of care, summaries of the patient's records are transferred to the health care professional to whom the patient was transferred and, if appropriate, to the organization where future care will be rendered.

Q. Discussions with the patient concerning the necessity, appropriateness and risks of proposed surgery, as well as discussions of treatment alternatives, are incorporated into the patient's medical record.

7

Note: ***Previously Professional Improvement, the standards in this chapter have been moved to other chapters in the*** **Handbook,** ***including Governance, Administration, and Quality Management and Improvement, where they are more consistent with the requirements of those areas.***

8 Facilities and Environment

An accreditable organization provides a functionally safe and sanitary environment for its patients, personnel, and visitors. Such an organization has the following characteristics.

A. The organization ensures that its facilities:

1. comply with applicable state and local building codes and regulations
2. comply with applicable state and local fire prevention regulations (The *NFPA 101® Life Safety Code®, 2000 Edition,* published by the National Fire Protection Association, Inc., is a commonly accepted guideline among states and localities.[1])
3. comply with applicable federal regulations
4. are inspected at least annually by the local or state fire control agency, if this service is available in the community
5. contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type
6. have prominently displayed illuminated signs with emergency power capability at all exits from each floor or hall
7. have emergency lighting, as appropriate to the facility, to provide adequate evacuation of patients and staff, in case of an emergency
8. have stairwells protected by fire doors
9. are operated in a safe and secure manner.

B. The organization has the necessary personnel, equipment and procedures to handle medical and other emergencies that may arise in connection with services sought or provided.

C. The organization provides documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment.

D. The organization has a comprehensive emergency plan to address internal and external emergencies, including a provision for the safe evacuation of individuals during an internal emergency, especially individuals who have difficulty walking.

E. The organization requires at least four drills per year of the internal emergency plan.[2] One of these must be a documented cardiopulmonary resuscitation technique drill, as appropriate to the organization.

F. Personnel trained in cardiopulmonary resuscitation and the use of cardiac emergency equipment are present in the facility during hours of operation.

G. Smoking is prohibited in such areas as operating rooms, anesthetizing locations, rooms where oxygen and other volatile gases are administered or stored, and other hazardous areas. Smoking is permitted only in designated areas.

H. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning or other trauma are eliminated.

I. Reception areas, toilets, and telephones are provided in accordance with patient and visitor volume.

J. When appropriate, adequately marked patient and visitor parking is provided.

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[1] *Life Safety Code and NFPA 101* are registered trademarks of the National Fire Protection Association, Inc., Quincy, Massachusetts. For those organizations desiring assistance in reviewing applicable NFPA 101 code, a suitable reference is the Physical Environment Checklist for Ambulatory Surgical Centers, available from AAAHC.

[2] Appropriate to the facility's activities and environment. Examples include medical emergencies, building fires, surgical fires, tornados, hurricanes, earthquakes, bomb threats, violence, and chemical, biological or nuclear threats.

K. Provisions are made to reasonably accommodate disabled individuals.

L. All examination rooms, dressing rooms, and reception areas are constructed and maintained in a manner that assures patient privacy during interviews, examinations, treatment and consultation.

M. Adequate lighting and ventilation are provided in all areas.

N. Facilities are clean and properly maintained.

O. Food snack services and refreshments provided to patients meet their clinical needs and are prepared, stored, served and disposed of in compliance with local health department requirements.

P. Procedures should be available to minimize the sources and transmission of infections, including adequate surveillance techniques.[3]

Q. A system exists for the proper identification, management, handling, transport, treatment and disposal of hazardous materials and wastes, whether solid, liquid or gas.

1. The system includes, but is not limited to, infectious, radioactive, chemical and physical hazards.

2. The system provides for the protection of patients, staff, and the environment.

R. The space allocated for a particular function or service is adequate for the activities performed therein, including space allocated for pathology and medical laboratory services, radiology services, pharmaceutical services, examination and treatment rooms, offices, operating rooms, recovery areas, storage rooms, reception areas, clinical records and other special function areas.

S. Appropriate emergency equipment and supplies are maintained and readily accessible to all areas of each patient care service site.

T. Equipment is properly maintained and periodically tested.

U. Alternate power, adequate for the protection of the life and safety of patients and staff, is available in all patient care areas including operative and recovery areas for surgical services, treatment areas, and where emergency services are provided.

[3] Guidelines on reprocessing flexible gastrointestinal endoscopes were endorsed by several health organizations and published in the following journal: *Gastrointestinal Endoscopy,* Vol. 58, No.1, July 2003.

Additional Medicare Requirements
Medicare requirements will be applied by the AAAHC in surveys when an ambulatory surgery center elects to have an AAAHC/Medicare deemed status survey, which may be recognized for purposes of Medicare certification.

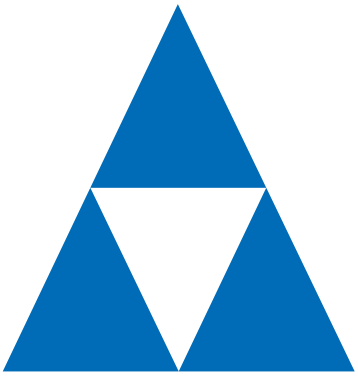
N-MS. An ambulatory surgery center must have a separate recovery room and waiting area.

O-MS. In an ambulatory surgery center, emergency equipment available to the operating room must include at least the following:

1. *Emergency call system*
2. *Oxygen*
3. *Mechanical ventilatory assistance equipment, including airways, manual breathing bag and ventilator*
4. *Cardiac defibrillator*
5. *Cardiac monitoring equipment*
6. *Tracheostomy set*
7. *Laryngoscopes and endotracheal tubes*
8. *Suction equipment*
9. *Emergency medical equipment and supplies specified by the medical staff*

Medicare ASC Conditions of Coverage require that every Medicare certified ASC must meet the provisions of the *NFPA 101® Life Safety Code®, 2000 Edition* that are applicable to ambulatory surgical centers. Therefore, every ASC applying for an AAAHC/Medicare deemed status survey is subject to this requirement.

Note: *AAAHC will determine whether the organization is in compliance with the Medicare Conditions of Coverage for ASCs as stated in 42 CFR 416, including the requirements of the* NFPA 101® Life Safety Code®, 2000 Edition.



Adjunct Standards

The applicable portions of the core standards will be evaluated based on the services provided by the organization.

9 Anesthesia Services

Anesthesia services in an accreditable organization are provided in a safe and sanitary environment by qualified health care professionals who have been granted privileges to provide those services by the governing body. Such an organization has the following characteristics.

The provisions of this chapter apply to all care involving administration of sedation and anesthesia in all ambulatory settings, including office-based settings. The following definitions are used in determining application of this chapter or standards thereof depending on the level of anesthesia and sedation administered by an organization:

Standards A-H of this chapter will be applied to organizations where only local or topical anesthesia or only minimal sedation is administered.

Definitions:

Local or ***topical anesthesia*** is the application of local anesthetic agents, in appropriate doses adjusted for weight.

Minimal sedation (anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Inhaled nitrous oxide in low concentrations that would not reasonably be expected to result in loss of the patient's life-preserving protective reflexes would be considered minimal sedation.

Standards A-V of this chapter will be applied to organizations that administer moderate sedation/ analgesia or regional anesthesia.

Moderate sedation/analgesia (conscious sedation) is a drug-induced depression of consciousness during which patients respond purposefully[1] to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Regional anesthesia is the application of anesthetic medication around the nerve or nerves in a major region of the body, which supply the area that is targeted for the abolition of painful neural impulses. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

All standards of this chapter will be applied to organizations that administer deep sedation or general anesthesia.

Deep sedation/analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully[1] following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Note: *Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Individuals administering minimal or moderate sedation/analgesia or regional anesthesia should be able to support the respiratory and cardiovascular system of patients who enter a state of deep sedation/analgesia, while those administering deep sedation/analgesia should be able to support the respiratory and cardiovascular system of patients who enter a state of general anesthesia.*

[1] Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Standards A-H below will be applied at organizations involved in the administration of sedation and anesthesia as defined on page 44, including those where only local or topical anesthesia or only minimal sedation is administered.

A. Anesthesia services provided in the facilities owned or operated by the organization are limited to those techniques that are approved by the governing body upon the recommendation of qualified professional personnel. Anesthesia services are performed only by health care professionals who have been credentialed and granted clinical privileges by the organization in accordance with Chapter 2-II.

B. Adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians or dentists who are approved and have privileges granted by the governing body.

C. Policies and procedures are developed for anesthesia services which include, but are not limited to:

1. education, training and supervision of personnel
2. responsibilities of non-physician anesthetists
3. responsibilities of supervising physicians and dentists.

D. A physician, dentist, or a qualified[2] individual supervised by a physician or dentist, approved by the governing body, has examined the patient immediately prior to the anesthetic to evaluate the risks of anesthesia relative to the procedure to be performed and has developed and documented a plan of anesthesia.[3]

E. The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed. One consent form may be used to satisfy the requirements of this standard and Standard 10-Q.

F. Anesthesia is administered by anesthesiologists, other qualified physicians, dentists, certified registered nurse anesthetists, other qualified[2] individuals supervised by a physician or dentist and credentialed by the governing body pursuant to Chapter 2-II, or supervised trainees in an approved educational program.

G. The facility must be established, constructed, equipped and operated in accordance with applicable local, state and federal laws and regulations. At a minimum, all settings where sedation or anesthesia is administered should have the following equipment for resuscitation purposes:

1. reliable and adequate source of oxygen delivery
2. a device such as a self-inflating hand resuscitator bag capable of administering at least 90% oxygen
3. appropriate emergency drugs, supplies and equipment
4. appropriate monitoring equipment for the intended anesthesia care
5. reliable suction source and appropriate equipment to assure a clear airway.

[2] A qualified individual is one who is qualified by virtue of education, experience, competence and where applicable, professional licensure, state laws, rules and regulations.

[3] For organizations that are Medicare certified or seeking Medicare certification, the additional Medicare-Related Standards found at the end of this chapter supersede the AAAHC standards B, D, L-2, and N.

H. Clinical records include entries related to anesthesia administration.

Standards I-V below will be applied at organizations that administer moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia.

I. A patient's oxygenation, ventilation and circulation must be continually evaluated and documented. Intra-operative physiologic monitoring must include continuous use of a pulse oximeter, blood pressure determination at frequent intervals and EKG monitoring for patients with significant cardiovascular disease during moderate sedation and for all patients during deep sedation/analgesia or general anesthesia. Monitoring for the presence of exhaled CO_2 is recommended during the administration of deep sedation.

J. The organization maintains a written policy with regard to assessment and management of acute pain.

K. The patient is observed and monitored in a post-anesthesia care unit or in an area which provides equivalent care by methods appropriate to the patient's medical condition and sedation or anesthesia.

L. 1. A physician or dentist is present until the medical discharge of the patient following clinical recovery from surgery and anesthesia.

2. Before medical discharge from the facility, each patient must be evaluated by a physician, dentist, or a delegated qualified[2] individual supervised by a physician or dentist, approved by the governing body to assess recovery. If medical discharge criteria have previously been set by the treating physician or dentist, and approved by the governing body, a delegated qualified[2] individual may determine if the patient meets such discharge criteria, and if so, may discharge when those criteria are met.[3]

M. Personnel qualified in advanced resuscitative techniques (ACLS or when pediatric patients are served, PALS) are present until the patient has been physically discharged.

N. Patients who have received moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia are discharged in the company of a responsible adult.[3]

O. A safe environment for providing anesthesia services is assured through the provision of adequate space, equipment, supplies, medications, and appropriately trained personnel. All equipment should be maintained, tested and inspected according to the manufacturer's specifications with a log maintained of regular preventive maintenance.

P. Alternative power adequate for the type of surgery/service being performed is available in operative and recovery areas.

Q. Written protocols and emergency equipment and drugs for the treatment of malignant hyperthermia are maintained and immediately available, if the organization administers agents known to trigger malignant hyperthermia. (Please see Appendix K for additional information on malignant hyperthermia.)

R. Malignant hyperthermia drills are performed at least yearly if the organization administers agents known to trigger malignant hyperthermia.

S. The organization has a written protocol in place for the safe and timely transfer of patients to a prespecified alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. Standard 10-M addresses medical emergencies that arise in connection with surgical procedures.

T. Where anesthesia services are provided to infants and children, the required equipment, medication and resuscitative capabilities appropriate to pediatric patients are on site.

U. No patient shall receive moderate or deep sedation or general anesthesia unless a physician, dentist, or other qualified[2] individual supervised by a physician or dentist, in addition to the one performing the surgery, is present to monitor the patient. The operating physician or dentist may be the supervising physician or dentist. During moderate sedation, the additional individual may assist with minor, interruptible tasks.

V. Organizations that provide sedative, hypnotic or analgesic drugs that do not have an antagonist medication (for example, propofol) will identify who in the organization is privileged to administer these drugs.

Standards W and X will be applied at organizations that administer deep sedation or general anesthesia.

W. The organization will have a written protocol that explains how the organization will respond in the event that a deeper-than-intended level of sedation occurs.

X. In addition to the items noted in the previous anesthesia section, Standard I, administration of general anesthesia requires:

1. end-tidal CO_2 monitoring
2. a means of measuring body temperature must be readily available.

Additional Medicare Requirements

Medicare requirements will be applied by the AAAHC in surveys when an ambulatory surgery center elects to have an AAAHC/Medicare deemed status survey, which may be recognized for purposes of Medicare certification.

B-MS. In those cases in which a non-physician administers the anesthesia, an anesthesiologist's assistant must be under the supervision of an anesthesiologist, and a certified registered nurse anesthetist must be under the supervision of the operating physician unless the state in which the ASC is located has opted out of the physician supervision requirement pursuant to 42 CFR 416.42(d).

D-MS. A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.

L-MS. Before discharge from the ambulatory surgery center, each patient must be evaluated by a physician for proper anesthesia recovery.

N-MS. All patients are discharged in the company of a responsible adult, except those exempted by the attending physician.

10 Surgical and Related Services

Surgical services in an accreditable organization are performed in a safe and sanitary environment by qualified health care professionals who have been granted privileges to perform those procedures by the governing body. The provisions in this chapter are applied to organizations that provide any invasive procedures, such as pain management, endoscopy procedures, cardiac catheterization, lithotripsy and in vitro fertilization, as well as surgery. Such an organization has the following characteristics.

Note: **Some standards may not apply to organizations that only perform minor, superficial procedures without anesthesia or under local or topical anesthesia.**

A. Surgical procedures performed in the facilities owned and operated by the organization are limited to those procedures that are approved by the governing body upon the recommendation of qualified medical personnel.

B. Adequate supervision of surgery conducted by the organization is a responsibility of the governing body. It is recommended that supervision be provided by an anesthesiologist, another physician or dentist.

C. Surgical procedures are performed only by health care professionals who:

1. are licensed to perform such procedures within the state in which the organization is located
2. have been granted privileges to perform those procedures by the governing body of the organization, in accordance with Chapter 2-II.

D. Surgical procedures to be performed in a solo office-based surgical practice are reviewed periodically as part of the peer review portion of the organization's quality improvement program.

E. An appropriate and current history, including a list of current medications, and dosages if known, physical examination, and pertinent pre-operative diagnostic studies are incorporated into the patient's medical record prior to surgery.

F. The necessity or appropriateness of the proposed surgery, as well as any available alternative treatment techniques have been discussed with the patient prior to scheduling for surgery.

G. Registered nurse(s) and other personnel assisting in the provision of surgical services are appropriately trained and supervised, and are available in sufficient numbers for the surgical and emergency care provided.

H. Each operating room is designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and ensures the physical safety of all persons in the area. At least one operating room is available for surgery. Only nonflammable agents are present in an operating room, and the room is constructed and equipped in compliance with applicable state and local fire codes.

I. Personnel qualified in advanced resuscitative techniques (ACLS or when pediatric patients are served, PALS) are present until all patients operated on that day have been physically discharged. At least one physician or dentist is present or immediately available by telephone any time patients are present.

J. With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's record.

K. The findings and techniques of an operation are accurately and completely documented immediately after the procedure and authenticated by the health care professional who performed the operation. This description is immediately available for patient care and becomes a part of the patient's record.

L. A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is assured through the provision of adequate space equipment and personnel.

1. Provisions have been made for the isolation or immediate transfer of patients with a communicable disease.
2. All persons entering operating rooms are properly attired.
3. Acceptable aseptic techniques are used by all persons in the surgical area.
4. Only authorized persons are allowed in the surgical or treatment area, including laser rooms, and such persons must decontaminate hands either by using a hygienic hand scrub or by washing with a disinfectant soap prior to and after direct contact with each patient.
5. Suitable equipment for rapid and routine sterilization is available to ensure that operating room materials are sterile.
6. Sterilized materials are packaged and labeled in a consistent manner to maintain sterility and identify sterility dates.
7. Environmental controls are implemented to ensure a safe and sanitary environment.
8. Suitable equipment is provided for the regular cleaning of all interior surfaces.
9. Operating rooms are appropriately cleaned before each operation.

M. When hospitalization is indicated to evaluate, stabilize and transfer when emergencies or unplanned outcomes occur, the organization shall have one of the following:

1. written transfer agreement for transferring patients to a nearby hospital, or
2. permits elective surgery only by physicians and dentists who have admitting and similar privileges at a nearby hospital, or
3. a detailed procedural plan for handling medical emergencies, and this plan shall be submitted to AAAHC for review during the survey process.

N. As necessary and appropriate for the type of surgery performed at the organization, procedures have been developed for obtaining blood and blood products on a timely basis.

O. Alternate power adequate for the type of surgery performed is available in operative and recovery areas.

P. Periodic calibration and/or preventive maintenance of equipment is provided.

Q. The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed.

R. The organization utilizes a process to identify and/or designate the surgical procedure to be performed and the surgical site, and involves the patient in that process. The person performing the procedure marks the site. For dental procedures, the operative tooth may be marked on a radiograph or a dental diagram.

S. Immediately prior to beginning a procedure, the operating team verifies the patient's identification, intended procedure, correct surgical site and that all equipment routinely necessary for performing the scheduled procedure, along with any implantable devices to be used, are immediately available in the operating room. The operating surgeon is personally responsible for ensuring that all aspects of this verification have been satisfactorily completed immediately prior to beginning the procedure.

T. A procedure has been established for the observation and care of the patient during the pre-operative preparation and post-operative recovery periods. Upon completion of a patient's procedure and until medical discharge, the staff performs repeated, frequent assessments of the patient's blood pressure or hemodynamic status, oxygen saturation, level of consciousness, pain relief and condition of the procedure site as appropriate.

U. Protocols have been established for instructing patients in self-care after surgery, including written instructions to be given to patients who receive moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia or general anesthesia.

Standard V will be applied to organizations that provide surgical, diagnostic and/or therapeutic services to children.

V. A safe environment for treating pediatric surgical patients is assured through the provision of adequate space, equipment, supplies, medications and personnel.

Standards W, X, and Y will be applied to organizations that utilize laser technology.

W. Policies and procedures should be established and implemented for laser technology which include, but are not limited to:

1. laser safety programs
2. education and training of laser personnel, including a requirement for all personnel working with lasers to be adequately trained in the safety and use of each type of laser utilized in patient care.

X. The organization ensures that its facility provides a safe environment for utilizing laser technology, including:

1. granting privileges for each specific laser
2. ensuring that only authorized persons are allowed in treatment areas
3. utilization of door and window coverings, where appropriate
4. prominently displayed warning signs being present only during laser procedures at the entrance to laser treatment areas
5. utilization of laser protective eyewear by personnel in treatment areas
6. when appropriate, utilization of smoke evacuators and utilization of appropriate devices to control tissue debris, high filtration masks and/or wall suction with filters to minimize laser plume inhalation
7. utilization of appropriate disinfectant or sterilization of laser components that have direct patient contact
8. ensuring appropriate laser fire protection, including:
   a. the immediate availability of electrical-rated fire extinguishers for equipment fires
   b. the maintenance of a wet environment around the operative field and the immediate availability of an open container of saline or water where ignition of flammable materials is possible
   c. the use of "laser safe" equipment and/or techniques, especially for procedures in and around the airway
   d. the utilization of non-combustible materials, supplies and solutions as appropriate
   e. that drape material is not positioned in front of the laser beam. Drapes should be checked prior to use of laser to insure that material has not shifted during the procedure.
9. documenting that laser maintenance logs are current and visually inspecting and testing the laser before each use.

Y. The organization ensures patient safety, including:

1. assurance that procedures are done in accordance with manufacturer guidelines and are consistent with the current version of the ANSI American National Standard for Safe Use of Lasers in Health Care Facilities[1]
2. protection of the patient's eyes, skin, hair and other exposed areas
3. when available, the use of non-reflective surgical instruments and supplies
4. appropriate patient education regarding laser procedure risks and potential complications.

Additional Medicare Requirements

Medicare requirements will be applied by the AAAHC in surveys when an ambulatory surgery center elects to have an AAAHC/Medicare deemed status survey, which may be recognized for purposes of Medicare certification.

G-MS. The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met. Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC.

M-MS. The ASC must have an effective procedure for transfer to a hospital for patients requiring emergency medical care beyond the capabilities of the ASC. The hospital must be a local Medicare participating hospital or a local non-participating hospital that meets the requirements for payment for emergency services under section 482.2 of Title 42 of Code of federal regulations. The ASC must have a written transfer agreement with such a hospital, or all physicians performing surgery in the ASC must have admitting privileges at such hospital.

MS. Exclusivity

This ambulatory surgery center must be a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

The space constituting the ambulatory surgery center must be exclusively used for ambulatory surgery or directly related activities.

Although the ambulatory surgery center need not be in a separate building from a physician's office or clinic, it must be separated physically by (at least) semi-permanent walls and doors.

The ambulatory surgery center and other entity do not mix functions and operations in a common space during concurrent or overlapping hours of operation.

Operating room and recovery areas must be used exclusively for surgical procedures.

Ambulatory surgery center staffing and record keeping must be separate and exclusive (for example, a nurse cannot provide coverage in the ambulatory surgery center and in an adjacent clinic at the same time.)

[1] Published by the Laser Institute of America, *www.laserinstitute.org*.

11 Overnight Care and Services

If an accreditable organization provides overnight care and related services, such care and services meet the needs of the patients served and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. The scope and limitations of overnight care and services are clearly specified. Such information is communicated to:

1. physicians who refer and admit patients to the program
2. staff who provide the care and services
3. potential patients in advance of their referral to the program
4. other health care professionals and relevant community agencies.

B. Adequate supervision of overnight care and services is the responsibility of one or more qualified physicians who are approved by the governing body upon the recommendation of qualified medical personnel.

1. At least one physician is present or immediately available by telephone any time that patients are present.
2. A patient is admitted or discharged only upon the order of a physician who is responsible for the medical care of that patient.

C. Health care professionals may admit patients to this program if they:

1. are licensed to treat patients or supervise care and services in this setting
2. have been granted such privileges by the governing body of the organization, in accordance with Chapter 2.II.

D. Policies and procedures are clearly specified that include, but are not limited to:

1. clinical criteria for determining eligibility for admission
2. clinical responsibility for each patient during his/her stay
3. arrangements for emergency services
4. arrangements for transfer to other health care services as needed.

E. The organization has a written transfer agreement with a nearby hospital or only grants admitting privileges to physicians who have admitting privileges at a nearby hospital.

F. The overnight care unit meets applicable local and state codes, including licensing requirements if the state licenses such units.

G. Registered nurse(s) and other personnel are appropriately trained and supervised and are available in sufficient numbers to meet patient needs.

H. At least one registered nurse is on duty at all times when patients are present.

I. Treatment rooms are provided or made available to meet patient needs and physician requirements.

J. Emergency power adequate for the size of the unit is available to protect the life and safety of patients.

K. Appropriate isolation procedures are followed when any patient is admitted with a suspected or diagnosed communicable disease.

Note: ***This chapter applies to organizations, or sub-units thereof, that provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, receiving treatment for non-critical illnesses or need only short-term or custodial care.***

L. Food service is provided to meet the needs of patients.

1. Food is purchased, stored, prepared and served in compliance with local health department requirements.
2. Special dietary requirements for patient care are met.
3. Personnel providing food services shall meet local health department requirements.

M. In addition to the applicable Clinical Records and Health Information requirements found in Chapter 6 of the *Handbook,* the records for overnight care and services shall include:

1. a current history and physical examination
2. treatment orders
3. nursing notes
4. follow-up instructions to patients.

N. If overnight care is the only service provided by the organization, that organization shall meet all other applicable standards contained in the *Handbook.*

O. Where overnight care is only one of many services provided by the organization, these services shall be functionally integrated to ensure compliance with all other applicable standards contained in the *Handbook.*

P. Overnight care and services are reviewed as part of the organization's quality improvement program.

12 Dental Services

Dental services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Dental services provided or made available are appropriate to the needs of the patients and are consistent with the definition of dentistry according to state regulation.

B. Dental services performed in the facilities owned and operated by the organization are limited to those procedures that are approved by the governing body upon the recommendation of qualified dental personnel.

C. Dental procedures are performed only by dental health professionals who:

1. are licensed to perform such procedures within the state or jurisdiction in which the organization is located

2. have been granted privileges to perform those procedures by the governing body of the organization, in accordance with Chapter 2.II.

D. Personnel assisting in the provision of dental services are appropriately qualified and available in sufficient numbers for the dental procedures provided.

E. An appropriate history and physical is conducted and periodically updated, which includes an assessment of the hard and soft tissues of the mouth.

F. The organization develops policies and procedures related to the identification, treatment and management of pain.

G. The necessity or appropriateness of the proposed dental procedure(s), as well as alternative treatments and the order of care, have been discussed with the patient prior to delivery of services.

H. The informed consent of the patient is obtained and incorporated into the dental record prior to the procedure(s).

I. Clinical records are maintained according to the requirements found in Chapter 6 of the *Handbook*.

J. The organization develops policies and procedures to evaluate dental laboratories to ensure they meet the needs of the patient and adequately support the organization's clinical capabilities.

K. Anesthesia provided or made available shall meet the standards contained in Chapter 9 of the *Handbook*.

L. Surgical and related services provided or made available shall meet the standards contained in Chapter 10 of the *Handbook*.

M. Imaging services provided or made available shall meet the standards contained in Chapter 17 of the *Handbook*.

1. The organization has guidelines to address the type, frequency and indications for diagnostic radiographs.

N. Personnel providing dental, surgical or anesthesia services are prepared to evaluate, stabilize and transfer medical emergencies that may occur or arise in conjunction with services provided by the organization.

O. The organization has a mechanism in place to evaluate and monitor dental products that the organization makes available for sale to patients to ensure such practices are done in an ethical manner.

13 Emergency Services

If an accreditable organization implies by its activities, advertising, or practice that it provides emergency services on a regular basis to meet life, limb or function-threatening conditions, such services meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Emergency services are provided 24 hours per day every day of the year.

B. Emergency services are performed only by health care professionals who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical personnel and after medical review of the health care professional's documented education, training, experience and current competence.

C. At least one qualified physician is present at all times.

D. Personnel assisting in the provision of emergency services are appropriately qualified, trained, and supervised and are available in sufficient numbers for the emergency services provided.

E. Unless otherwise provided for by the governing body, equipment, drugs and other agents recommended by the *Emergency Care Guidelines* of the American College of Emergency Physicians are available.

F. Laboratory and radiology services described in Chapters 16 and 17 of the *Handbook* are immediately available.

G. Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, poison control centers and hospitals as needed to ensure high-quality patient care.

H. Adequate specialty consultation services are immediately available.

I. Health care professionals who maintain skills in advanced cardiac and trauma life support are present in the facility at all times.

J. All emergency services personnel maintain skills in basic cardiac life support.

Note: ***Organizations providing emergency services may obtain information on important areas of patient care from the American College of Emergency Physicians, 1125 Executive Circle, Irving, TX 75038, 800/798-1822. This information will assist organizations that are seeking accreditation for their emergency services to evaluate and improve the quality of care they provide.***

14 Immediate/Urgent Care Services

If an accreditable organization implies by its activities, advertising, or practice that it provides medical care of an urgent or immediate nature on a routine or regular basis, such care meets the needs of the patients and is provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. The range of services offered by the organization and its hours of operation are clearly defined and communicated to the public and relevant organizations.

B. Such organizations, unless they also provide emergency services, do not solicit patients with life-threatening conditions.

C. Patients seeking immediate/urgent care services are seen without prior appointments.

D. Immediate/urgent care services are performed only by health care professionals who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical personnel and after medical review of the health care professional's documented education, training, experience and current competence.

E. During hours of operation, at least one qualified physician is present or immediately available.

F. The organization is prepared in terms of personnel, equipment and procedures to evaluate, stabilize and transfer medical emergencies that may present themselves or arise in conjunction with services provided by the organization.

G. Equipment, drugs, and other agents necessary to provide immediate/urgent care services are available.

H. Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, poison control centers and hospitals as needed to ensure high-quality patient care.

I. Laboratory and radiology services described in Chapters 16 and 17 of the *Handbook* are available to meet the needs of patients receiving immediate/urgent care.

J. Arrangements have been made to ensure that adequate specialty consultation services are available.

K. Health care professionals who maintain skills in cardiac and trauma life support are present in the facility at all times.

15 Pharmaceutical Services

Pharmaceutical services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Pharmaceutical services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.

B. Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws.

C. Staff demonstrates knowledge of applicable state and federal pharmaceutical laws.

D. Records and security are maintained to ensure the control and safe dispensing of drugs in compliance with federal and state laws.

E. Staff informs patients concerning safe and effective use of medications consistent with legal requirements and patient needs.

F. Measures have been implemented to ensure that prescription pads are controlled and secured from unauthorized patient access, and pre-signed and/or postdated prescription pads are prohibited.

G. All medications, including vaccines and samples, are checked for expiration dates on a regular basis and expired items are disposed of in a manner that prevents unauthorized access and protects safety, and meets state and federal requirements.

H. All injectable medications drawn into syringes or oral medications removed from the packaging identified by the original manufacturer must be appropriately labeled if not administered immediately.

I. Pharmaceutical services provided by the organization are supervised by a licensed pharmacist or, when appropriate, by a physician or dentist who is qualified to assume professional, organizational and administrative responsibility for the quality of services rendered.

J. A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.

K. Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.

L. Patients are not required to use a pharmacy owned or operated by the organization.

Additional Medicare Requirements

Medicare requirements will be applied by the AAAHC in surveys when an ambulatory surgery center elects to have an AAAHC/Medicare deemed status survey, which may be recognized for purposes of Medicare certification.

B7-MS. Adverse reactions are reported to the physician responsible for the patient and are documented in the record.

B8-MS. Blood and blood products are administered only by physicians or registered nurses.

B9-MS. Orders given orally for drugs and biologicals are followed by a written order, signed by the prescribing physician.

Note: ***This chapter applies to any organization that uses drugs or pharmaceutical medical supplies, irrespective of the presence or absence of an on-site pharmacy.***

16 Pathology and Medical Laboratory Services

Pathology and medical laboratory services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Subchapter I-CLIA-Waived Tests: This subchapter applies only to health care organizations providing services that meet the Clinical Laboratory Improvement Amendments of 1988 (CLIA) requirements for waived tests.[1]

A. An accreditable organization:

1. meets the requirements for waived tests under CLIA (part 493 of Title 42 of the code of federal regulations) if it performs its own laboratory services, performs only waived tests, and has obtained a certificate of waiver,[2] and/or
2. has procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with CLIA if it does not perform its own laboratory services.

B. Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.

C. Pathology and medical laboratory services include, but are not limited to:

1. conducting laboratory procedures that are appropriate to the needs of the patients
2. performing tests in a timely manner
3. distributing test results after completion of a test and maintaining a copy of the results
4. performing and documenting appropriate quality control procedures, including, but not limited to, calibrating equipment periodically and validating test results
5. ensuring that staff performing tests have adequate training and competence to perform the tests.

D. Dated reports of all examinations performed, including those performed in outside laboratories, are made a part of the patient's clinical record, with documentation that the reports have been reviewed by the patient's health care professional.

Subchapter II-CLIA Laboratories: This subchapter applies only to health care organizations providing laboratory services that require certification under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

A. An accreditable organization providing laboratory services meets the requirements of CLIA (part 493 of Title 42 of the code of federal regulations) and has obtained a CLIA certificate.[2]

B. Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.

C. Pathology and medical laboratory services include, but are not limited to:

1. conducting laboratory procedures that are appropriate to the needs of the patients
2. performing tests in a timely manner
3. distributing test results after completion of a test and maintaining a copy of the results in the laboratory
4. performing and documenting appropriate quality assurance procedures, including, but not limited to, calibrating equipment periodically and validating test results through use of standardized control specimens or laboratories.

D. Dated reports of all examinations performed are made a part of the patient's clinical record, with documentation that the tests have been reviewed.

[1] According to the U.S. Department of Health and Human Services, certain tests on human specimens for the diagnosis, prevention or treatment of disease, or for the assessment of health, deemed to employ simple methodologies and pose no risk of harm to patients if performed incorrectly, are waived from CLIA certification requirements. For a current list of waived tests, see *www.cms.hhs.gov/clia/waivetbl.pdf*.

[2] For current CLIA laboratory requirements, see *www.phppo.cdc.gov/clia/regs/toc.aspx*.

E. Pathology and medical laboratory services provided by the organization are directed by a pathologist or another physician who is qualified to assume professional, organizational and administrative responsibility for the quality of services rendered.

F. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the laboratory.

G. Established procedures are followed in obtaining, identifying, storing and transporting specimens.

H. Complete descriptions are available of each test procedure performed by the laboratory, including sources of reagents, standards and calibration procedures, and information concerning the basis for the listed "normal" ranges is also available.

I. Sufficient space, equipment, and supplies are provided to perform the volume of work with optimal accuracy, precision, efficiency and safety.

J. Meets requirements of the Department of Health & Human Services (HHS) certification for medical review officer drug testing if the lab is testing for Department of Transportation (DOT) regulated industries or federal agency employees.

17 Diagnostic and Other Imaging Services

Imaging services, including those used for diagnosing, monitoring or assisting with procedures provided or made available by an accreditable organization, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Standards A-E of this chapter will be applied to organizations that provide imaging services used for diagnosing, monitoring or assisting with procedures. Standards F-K will be applied to organizations providing only diagnostic imaging services.

A. Imaging services provided or made available by the organization are appropriate to the needs of the patient and adequately support the organization's capabilities.

B. Imaging services include, but are not limited to:

1. providing radiographic, fluoroscopic, ultrasonic or other imaging services that are appropriate to the organization's function
2. interpreting images and assuring appropriate documentation in a timely manner
3. maintaining appropriate records or reports of services provided
4. providing adequate space, equipment and supplies to assure the provision of quality services.

C. Health care professionals providing imaging services and/or interpreting results:

1. have appropriate training and credentials
2. have been granted privileges to provide these services
3. have appropriate safety training and provide their services in a safe manner.

D. Policies that address the safety aspects of the imaging services include, but are not limited to:

1. regulation of the use, removal, handling, and storage of potentially hazardous materials
2. precautions against electrical, mechanical, magnetic, ultrasonic, radiation and other potential hazards
3. proper shielding where radiation, magnetic field, and other potentially hazardous energy sources are used
4. acceptable monitoring devices or processes to assure the safety of all personnel who might be exposed to radiation, magnetic fields or otherwise harmful energy
5. maintenance of appropriate exposure records
6. instructions to personnel in safety precautions and in dealing with accidental hazardous energy field exposure
7. periodic evaluation by qualified personnel of energy sources and of all safety measures followed, including calibration of equipment and testing the integrity of personal protective devices in compliance with federal, state, and local laws and regulations.

E. Proper warning signs are in place, alerting the public and personnel to the presence of hazardous energy fields, emphasizing concern for particularly susceptible individuals, including:

1. pregnant females
2. in cases of magnetic resonance imaging:
   a. patients with metal implantations
   b. patients or personnel with magnetically inscribed credit cards where appropriate
   c. patients or personnel wearing metallic objects capable of potentially dangerous motion
   d. patients with pacemakers or internal defibrillators.

F. A radiologist authenticates all examination reports, except reports of specific procedures that may be authenticated by specialist physicians or dentists who have been granted privileges by the governing body or its designee to authenticate such reports.

G. Authenticated, dated reports of all examinations performed are made a part of the patient's clinical record.

H. Diagnostic imaging services provided by the organization are directed by a physician or dentist who is qualified to assume professional, organizational and administrative responsibility for the quality of the services rendered.

I. Diagnostic imaging tests are only performed upon the order of a health care professional (such orders are accompanied by a concise statement of the reason for the examination).

J. Diagnostic images are maintained in a readily accessible location for the time required by applicable laws and policies of the organization.

K. A policy addresses the storage and retention of diagnostic images.

Additional Medicare Requirements

Medicare requirements will be applied by the AAAHC in surveys when an ambulatory surgery center elects to have an AAAHC/Medicare deemed status survey, which may be recognized for purposes of Medicare certification.

L-MS. An ambulatory surgery center (ASC) must have procedures for obtaining radiologic services from a Medicare approved facility to meet the needs of patients.

a. If the ASC itself provides directly for all radiological services, it must meet the Medicare conditions of participation for hospitals as they relate to radiological services (Section 482.26 of Title 42 of the Code of Federal Regulations), or conditions of coverage of portable x-ray services at 42 CFR 486(C).

b. When the ASC fails to meet either the radiology requirements for hospitals or portable x-ray equipment, then all radiology services must be obtained from a Medicare approved facility. Note, however, that a Medicare approved portable x-ray supplier is not a facility and cannot provide x-ray services to an ASC.

18 Radiation Oncology Treatment Services

Radiation oncology treatment services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

A. Radiation oncology treatment services that are provided or made available by the organization are appropriate to the needs of the patient and are adequately supported by the organization's capabilities.

B. Radiation oncology services appropriate to the organization's function include, but are not limited to:

1. consultation services
2. treatment planning
3. simulation of treatment
4. maintenance of reports of services and radiographic images appropriate to the therapy for the time required by applicable laws and policy of the organization
5. clinical treatment management including, but not limited to, teletherapy and brachytherapy
6. appropriate follow-up care of all patients.

C. Radiation oncology services provided by the organization are directed by a physician who is qualified to assume professional, organizational and administrative responsibility for the quality of services rendered.

D. Radiation safety and quality control policies and procedures are established, and are reviewed periodically by a qualified medical physicist.

E. The radiation oncology treatment service maintains sufficient adequately trained and experienced personnel who are able to supervise and conduct work of the service, including the following:

1. a radiation technologist certified by the American Registry of Radiation Technology (ARRT) or state-licensed technologist
2. dosimetrist
3. such other appropriately trained health care personnel as may be in keeping with local practice and legal requirements, such as oncology nurses, nutritionists and medical social workers.

F. The radiation oncology service should have adequate facilities and equipment to provide appropriate treatments and related treatments, which shall include:

1. isocentric supervoltage machine of at least 80 centimeters source-axis distance
2. low energy or electron-beam for skin lesions
3. access to computerized dosimetry
4. simulation capabilities
5. access to patient transport.

G. The radiation oncology service shall have policies addressing the quality of care including, but not limited to, policies providing for the following:

1. the facility shall have a recognized methodology for diagnosis and treatment
2. the performance of therapeutic services on the written order of a radiation oncologist
3. a physician shall be present or immediately available during treatment. In those situations in which the physician is not present but is immediately available, the physician shall have qualified support personnel present.

4. weekly chart and port film review
5. periodic new patient review
6. signed informed consent to be obtained prior to treatment
7. photo documentation of treatment setups
8. access to emergency treatment.

H. The radiation oncology service shall have policies addressing the safety aspects of treatment, including:

1. the designation of a radiation safety officer and committee that shall meet on a periodic basis
2. a program to maintain personnel exposure records
3. annual calibration of teletherapy units
4. annual review of the radiation safety program by a qualified medical physicist
5. a program to inspect interlock systems of all treatment units
6. maintenance of the records of machine performance, maintenance and malfunctions
7. periodic testing of all sealed sources satisfying all pertinent radiation regulations
8. a program for maintenance and repair of equipment
9. written quality control procedures for all therapeutic equipment
10. regulation of the use, removal, handling and storage of potentially hazardous materials.

I. The facility shall have access to appropriate supporting facilities, including diagnostic laboratories and imaging facilities.

J. In addition to the applicable Clinical Records and Health Information requirements found in Chapter 6 of the *Handbook*, the following characteristics indicate good-quality patient care in the radiation oncology setting and are documented:

1. confirmation of the presence of malignancy by histopathology or a statement of benign condition
2. definition of tumor location, extent and stage
3. definition of treatment volume
4. selection of dose
5. selection of treatment modality
6. selection of treatment technique
7. dosimetry calculations
8. supervision of treatment and record of patient progress and tolerance
9. summary of completion with statement of follow-up plan.

19 Employee and Occupational Health Services

Occupational health services provided by an accreditable organization are organized to ensure a safe and healthy workplace for employees through the recognition, evaluation and control of illness and injury in or from the workplace, and to meet the needs of the individuals served. These services are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Subchapter I - Employee Health in Health Care Settings: This subchapter applies to a health care organization which a) only provides services to its health care workers and b) limit such services to those listed in this subchapter.

Such an organization maintains a focused employee health program for its health care employees that minimizes risks of occupational injury and illness and complies with occupational health statutes. Such an organization has the following characteristics:

A. Health care workers are protected from biologic hazards, consistent with state, federal and CDC guidelines through:

1. an effective program addressing bloodborne pathogens including:
    a. exposure control plan designed to eliminate or minimize employee exposures
    b. Hepatitis B vaccination program
    c. post-exposure evaluation and treatment
    d. proper communication of hazards to employees
    e. appropriate record keeping and management.
2. an immunization program for other infectious agents of risk to health care workers and their patients
3. a tuberculosis respiratory protection program
4. programs addressing other relevant biological hazards, such as bioterrorism, as needed for employee safety and health.

B. A program is maintained to assess and reduce risks associated with occupational chemical exposures including:

1. hazard assessment of chemicals used in the workplace
2. engineering measures to reduce the risk of chemical exposure
3. worker training programs.

C. A program is maintained to assess, and where necessary, reduce risks associated with physical hazards. Consideration may be given to:

1. ergonomic exposures
2. violence at the workplace
3. external physical threats such as terrorism.

D. Records of work injuries or illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately.

Subchapter II - Occupational Health Services: This subchapter applies to organizations which provide services beyond those noted in subchapter I or provide services to individuals who are not their employees.

Such an organization provides employees and patients with extended occupational health services that minimize risks of occupational and environmental injury and illness, promote health, treat injury and occupational illness if it occurs and comply with relevant health statutes. Such an organization has the following characteristics:

A. Individuals who agree to laboratory testing or medical examinations at the request of their employer are afforded the rights noted in Chapter 1. In addition, they are informed of:

1. the purpose and scope of the evaluation and the role of the examiner
2. confidentiality protections and information which may be conveyed to the employer
3. whether medical follow-up is necessary.

B. Occupational health services are accurately portrayed to patients, employees and purchasers of the services.

C. Occupational health services are provided by personnel who:

1. have access to and utilize, as appropriate, consultative services associated with evaluating workplace hazards such as industrial hygiene, ergonomics, toxicology, occupational health nursing, epidemiology and boarded occupational medicine physicians
2. have ready access to appropriate reference materials in occupational health and participate in occupational health continuing medical education.

D. The provision of high-quality occupational health services is demonstrated by the following as appropriate:

1. an understanding of the specific workplace hazards for each employee/patient served
2. an understanding of the relationship of the condition or finding to workplace conditions and exposures
3. determination of whether the individual is able to perform essential functions of the job and whether accommodations are needed
4. preventive counsel concerning measures to reduce occupational exposures and hazards including use of protective equipment
5. compliance with occupational regulations such as the Occupational Safety and Health Act (OSHA), Americans with Disabilities Act (ADA), and state Workers' Compensation statutes concerning the organization's:
    a. personnel, their training and credentials
    b. policies, procedures and forms
    c. equipment, including calibration and maintenance
    d. medical records and record management.

E. Entries in a patient's record for each visit include as appropriate:

1. an occupational and exposure history including essential job functions, conditions of work and hazards of the job
2. the individual's current functional abilities
3. whether the individual is able to perform essential job functions and suggestions for accommodations or restrictions
4. the relationship of medical conditions or abnormal findings to workplace conditions and exposures
5. preventive counsel concerning reduction of workplace exposures and use of personal protective equipment
6. relevant communications concerning the patient, work activities or exposures including those with employers, insurance carriers, union representatives and attorneys.

F. Medical management of injury or illness minimizes disability and promotes functional recovery, directing special attention to cases where:

1. recovery has been delayed
2. functional abilities have decreased during treatment
3. injury or illness is recurrent
4. there is permanent impairment, disability or restriction.

G. Work placement evaluations such as preplacement, transfer or fitness for duty examinations assess current health and ability to perform the job as well as the extent and duration of recent health changes affecting job performance.

H. Organizations providing medical surveillance evaluations of employees to identify adverse effects from exposure to workplace hazards will assure that:

1. the health professionals performing or interpreting these evaluations have specific knowledge about the hazardous agent including its effects, permissible and actual exposure levels, biologic monitoring and regulatory requirements
2. whenever possible, surveillance data are statistically analyzed for health trends and effects of exposure
3. the results of workplace data for similar workers with similar exposures are considered for the evaluation of the employee.

I. Organizations providing certification examinations[1] mandated under state or federal statutes will assure that:

1. the health care professional performing the evaluation has access to the standard and related materials
2. the professional understands the statute as it relates to the exam.

J. Organizations providing occupational health testing and ancillary service programs such as urine collection for drugs of abuse, breath alcohol testing, blood lead determinations, audiograms or chest x-rays will assure that these programs are administered under appropriate written protocols which are:

1. specific to the service provided, addressing all relevant topics such as specimen collection, handling, transportation, receipt and report of results, record management, equipment, equipment calibration and maintenance
2. under the supervision of a licensed physician or, if allowed, another health care professional
3. reviewed and updated periodically.

K. Organizations providing consulting services will assure that there is a clear definition of the role and responsibilities of the consultant.

L. Organizations providing training and educational programs will assure that each program:

1. has written objectives
2. is tailored to the specific worker population and work conditions
3. includes an evaluation process and uses the results to improve program quality.

[1] Examples of certification examinations include, but are not limited to: Department of Transportation/Federal Highway Administration (DOT/FHWA) driver examinations or medical evaluations for respirator use, Federal Aviation Administration (FAA) certification exams, Nuclear Regulatory Commission (NRC) exams, and state-mandated driver license exams.

M. If the organization is responsible for emergency and/or community preparedness planning, it will assure that:

1. the disaster plan:
    a. includes likely worksite scenarios for disasters, estimating potential morbidity and mortality
    b. includes appropriate plans for medical segregation, decontamination, evacuation and transportation in collaboration with local emergency planning committees.
2. the toxicologic exposure plan:
    a. provides counsel on the identification, decontamination and evacuation of potentially exposed individuals or communities
    b. assures appropriate emergency treatment protocols for the potentially acute exposures to toxic agents handled by employees
    c. provides appropriate medical expertise for the case management of individual acute toxic exposures
    d. provides sufficient training and exercises to assure that the plan will be effective.

20 Other Professional and Technical Services

Professional and technical services provided or made available by an accreditable organization, even though they are not specifically mentioned in the *Handbook*, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Subchapter I - General Services: This subchapter applies to organizations that provide other professional and technical services. Such an organization has the following characteristics:

A. Such services may include, but are not limited to, various medical specialties, rehabilitation services (physical, occupational, vocational therapy), massage therapy, acupuncture, registered dieticians, certified diabetic educators, psychologists, social workers, optometrists, audiologists and other individuals who provide services to patients and submit charges for their services separately from a physician.

B. Such services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.

C. Such services are provided by personnel who have been selected in accordance with Standard 2-II-F.

D. Such services are provided in accordance with ethical and professional practices and applicable federal and state laws and regulations.

E. Such services will be evaluated by using applicable standards from other chapters of the *Handbook.*

Subchapter II - Travel Medicine: This subchapter applies only to organizations that provide travel medicine services. Such an organization has the following characteristics:

A. Organizations providing travel medicine services will assure that these services are appropriate to the needs of the patient and are adequately supported by the organization's clinical capabilities.

1. Travel medicine services are provided by personnel who have appropriate training, skills and resource materials to provide quality services.
2. Travel medicine programs include:
    a. appropriate medical oversight
    b. clearly defined standing orders and protocols including management of adverse reactions to immunizations
    c. access to current CDC and State Department travel recommendations
    d. appropriate storage and management of vaccines.
3. Travel medicine services include:
    a. comprehensive travel destination-specific risk assessment
    b. appropriate preventive medicine interventions
    c. education in risk and risk reduction.
4. Entries in a patient's clinical record include:
    a. travel destination and current health status
    b. immunizations(s) given and dosage
    c. medication(s) given, quantity and date
    d. preventive health education.

21 Teaching and Publication Activities

If staff are involved in teaching or publishing, an accreditable organization has policies governing those activities that are consistent with its mission, goals and objectives. Such an organization has the following characteristics.

A. Policies concerning teaching activities address:

1. the terms and conditions of reimbursement or other compensation
2. the reasonableness of the time spent away from direct patient care and administrative activities
3. the training of all students and postgraduate trainees, including the extent of their involvement in patient care activities.

B. The policy concerning the provision of health care by personnel in any student or postgraduate trainee status provides for close and adequate supervision and for informing the patient of the status of the health care professional.

C. Policies concerning publishing activities address:

1. the need for governing body approval when the views, policies and procedures expressed in the publication are attributed to the organization
2. the terms and conditions of compensation from publication and the cost of publication.

22 Research Activities

If research is conducted, an accreditable organization establishes and implements policies governing research that are consistent with its mission, goals and objectives, and with its clinical capabilities. Such an organization has the following characteristics.

A. Research activities are performed in accordance with ethical and professional practices and legal requirements, and these activities are periodically monitored. Such activities include, but are not limited to, clinical trials of drugs and other biologicals, devices, implants or instruments that are classified as investigational or experimental, and techniques that are new, experimental, innovative or otherwise not yet accepted as standard medical or dental practice.

B. The protocols for conducting research are approved by the governing body or its designee after medical (or dental) and legal review.

C. Any research activities carried out within the organization are appropriate to the expertise of staff and the resources in the organization.

D. Individuals engaged in research are provided with adequate facilities.

E. Provisions are made to ensure that the rights and welfare of all research subjects are adequately protected and that the informed consent of the subject, in the language spoken by him or her, is obtained by adequate and appropriate methods.

F. All professional staff are informed of the organization's research policies.

23 Managed Care Organizations

An accreditable managed care organization provides for the management of a system of health care and is accountable for the quality of services delivered. Such an organization has the following characteristics.

A. The managed care organization has a system in place to provide a network of primary and specialty care providers that meets the needs of the population served and has policies and procedures to communicate to all patient members information about its benefits, services and network capability to provide a full spectrum of care.

B. The managed care organization has an organized and timely system for resolving patient members' grievances, with an expedited procedure for emergency cases, including provisions for identifying, analyzing and evaluating grievances and appeals, and methods for notifying patient members/enrollees and/or providers of the resolution of grievances and appeals, if applicable.

1. The organization ensures that individuals reviewing a grievance involving an adverse determination have appropriate expertise. Individuals with the appropriate clinical expertise review grievances of a clinical nature.
2. The organization establishes written procedures for review of an adverse determination.
3. The review procedures are available to the patient and any provider acting on behalf of a patient.
4. The organization issues a copy of the written decision of the review panel to the patient and to any provider who submits a grievance on behalf of a patient.
5. The organization establishes written procedures for an expedited review of an urgent grievance. The expedited reviews are evaluated by appropriate clinical peers or peers who have not been involved in the initial adverse determination. In an expedited review, the organization makes a decision and notifies the patient, or provider acting on behalf of the patient, as expeditiously as the patient's medical condition requires.
6. The organization provides a system for the reporting, collection and analysis of patient member appeals and grievances, including methods for establishing a linkage between the organization's quality improvement activities and provider member credentialing.

C. Information is provided to patient members concerning:

1. specialty referral policy
2. when to seek direct access to emergency care or utilize 911 services
3. policies regarding services obtained outside the managed care organization and procedures for obtaining them
4. policies on patient member charges (if any)
5. procedures for patient member notification on benefit changes and/or termination of benefits, services or service delivery
6. procedures for appealing decisions regarding coverage, benefits or services, as required by applicable state or federal law and regulations.

D. Policies and procedures, including an established appointment system, appropriate to the organization, are in place to ensure that services are accessible to patient members and that patient members are aware of access points to primary and specialty care and hospital services.

E. Procedures are in place to periodically assess patient satisfaction with the organization's services and provide feedback to providers.

F. There is a Utilization Management Program which includes:

1. policies and procedures to evaluate medical necessity, criteria used, information sources, monitors for over-under-utilization and the review and approval process used to provide medical services
2. decision protocols are based on medical evidence
3. policies and procedures are in place to evaluate the appropriate use of new medical technologies, procedures, drugs or devices
4. evaluation of the Utilization Management Program including patient member and provider satisfaction data.

G. Practice guidelines or protocols based on medical evidence and population demographics are adopted and monitored/measured for evidence of effectiveness of the program or for improvement. These protocols are updated periodically based on the monitoring process with the intent of continuous quality improvement.

H. The managed care organization sets policies and procedures for the quality management and improvement program as required in Chapter 5 of this *Handbook,* including, but not limited to, patient rights, as required in Chapter 1 (grievances, appeals, satisfaction, etc.); governance (credentialing), as required in Chapter 2; administration, as required in Chapter 3 (patient continuity, patient health education, etc.); and other patient access, cost and quality of care issues as required in Chapter 4.

1. Goals of the quality improvement program are established and designed to achieve the greatest benefit to the patient members.
2. Identification and selection of appropriate quality improvement activities are based on information obtained from the following sources, including, but not limited to:
   a. patient member demographics
   b. patient member and provider surveys
   c. reports of high-risk, high-volume diagnosis and services.
3. The governing body, at least annually, reviews the effectiveness of the program goals and initiates changes, as appropriate.

I. The managed care organization sets policies/ procedures for clinical records, performs a periodic review for conformance to standards, and initiates corrective action when standards are not met.

1. Records in the patients' primary clinical record include a summary of significant surgical procedures, and past and current diagnoses or problems.

J. The managed care organization sets policies/ procedures for provider member credentialing, performs a periodic review for conformance to the credentialing standards, and initiates corrective action when standards are not met.

K. The managed care organization sets written policies/ procedures for the provider member's participation, including reducing, suspending or terminating a health care professional's privileges.

1. Procedures should include, but are not limited to:
   a. methods for notifying providers of a participation decision
   b. methods for filing an appeal when privileges are denied, reduced, suspended or terminated.

L. The managed care organization sets policies/ procedures for reporting, reviewing and appropriate analysis of all incidents reported by employees, patients, providers and others.

M. The managed care organization is accountable for the oversight of any functions or services that are delegated[1] to another entity.

1. A system must be in place to evaluate the services of the delegated entity, prior to delegation.
2. A written agreement must be in place that outlines the services to be performed by the delegated entity, including reporting responsibilities.
3. Ongoing monitoring of the performance of the entity must be conducted at least annually, with corrective measures taken as appropriate.
4. If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend or terminate the individual provider or provider group.

N. The managed care organization works to improve the health status of its members with chronic conditions.

O. The managed care organization is responsible for confirming that provider organizations that it contracts with, such as surgery centers, hospitals, home health agencies, nursing homes, behavioral health providers, pathology and medical laboratories (those services listed in the Adjunct Chapters), have been reviewed and approved by a recognized accrediting body. The managed care organization must develop and implement standards of participation, if a recognized accrediting body has not approved the provider organization.

Note: *Standard O focuses on the managed care organization's system-wide mechanisms for evaluating the individual physicians' office or other contractor practice sites and for assuring standards compliance.*

[1] **Delegation** is defined as a formal process by which a managed care organization gives another organization the authority to perform certain administrative functions on its behalf, such as credentialing, utilization management, and quality improvement. Although a managed care organization can delegate the authority to perform a function, it cannot delegate the responsibility for assuring that the function is performed appropriately and in compliance with AAAHC standards. The organization fulfills its responsibility and exercises it authority by providing oversight of the delegate.

24 Health Education and Health Promotion

AAAHC encourages all health care organizations to provide or make available health education and health promotion services to meet the needs of the population served. These services should be provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Standards A-G will be applied to all health education and health promotion services. Standards H-J will be applied to organizations providing comprehensive health education and disease prevention programs.

A. Services provided or made available by the organization are appropriate to the needs of the population served.

B. Health education and health promotion services are provided by personnel that:

1. have necessary and appropriate training, education, credentials and skills to carry out their responsibilities
2. have access to and utilize, as appropriate, consultative services
3. have ready access to appropriate reference materials in health education and health promotion
4. participate in continuing professional education in health education and wellness.

C. Health education and health promotion programs should include, but may not be limited to:

1. clearly defined educational goals and objectives
2. evaluation of whether the goals or objectives have been met.

D. The organization should have adequate resources for the health education and health promotion services available.

E. Marketing or advertising regarding the health education and health promotion activities accurately reflects the services provided by the organization.

F. Policies and procedures are established to assess satisfaction with the health education and health promotion services.

G. When appropriate, health education and health promotion services, whether they occur within the context of a clinical visit or not, should be referenced or documented in the patient's clinical record.

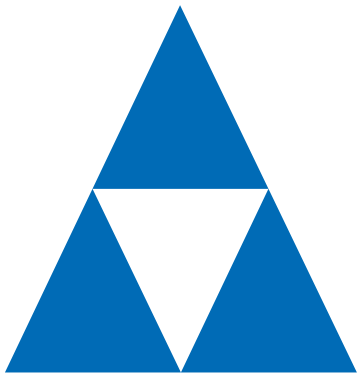
H. Health education and disease prevention programs should be based on a complete needs assessment for the population served, which:

1. considers relevant health risks and health education needs
2. uses a variety of data or data sources
3. quantifies risk whenever possible
4. uses data to direct programming

I. Health education and disease prevention programs should be comprehensive and consider the medical, psychological, social and cultural needs of the population. Topics which should be considered include:

1. disease-specific screening and educational programs
2. substance abuse prevention and education, including programs related to alcohol, tobacco and other drugs
3. promotion of healthy eating
4. promotion of physical fitness
5. sexuality education and skill building for healthy relationships
6. sexual, physical and emotional violence prevention
7. promotion of and education about stress management and relaxation

J. Health education and disease prevention programs should be included in quality management and improvement activities.



Appendices

Appendix A
Revisions to the *AAAHC Accreditation Handbook for Ambulatory Health Care* Since the 2006 Edition

Chapter 8 – Facilities and Environment

8.A-9. A new element has been added to this standard, specifying that an organization must ensure that its facilities are also operated in a safe and secure manner. The new element is consistent with Chapter 2 – Governance, Subchapter I – General Requirements, Standard 2.I.B-19 that the organization's facilities and environment are safe.

Chapter 9 – Anesthesia Services

9.I An additional sentence has been added to the standard, to recommend the monitoring of the presence of exhaled CO_2 during the administration of deep sedation.

9.P The language "emergency power" has been changed to "alternate power" for consistency.

9.V Owing to its significance, the reference to the need for a written protocol that explains how the organization will respond in the event that a deeper than intended level of sedation occurs has been deleted from this standard and made a full standard (standard 9.W.)

9.W See Standard 9.V above.

9.X Formerly standard 9.W, this standard has been revised to highlight two elements: that the administration of general anesthesia requires end-tidal CO_2 monitoring and that a means of measuring body temperature be made readily available.

Chapter 10 – Surgical and Related Services

10.O The language "emergency power" has been changed to "alternate power" for consistency among standards.

Chapter 17 – Diagnostic and Other Imaging Services

The title for this chapter was amended to include 'and other' imaging services. The chapter has also been reorganized and some language revised to broaden the scope of imaging services to include imaging services for monitoring or assisting with procedures, as well as diagnosing.

A note was added in this chapter to clarify that Standards A-K of this chapter will be applied to organizations providing imaging services used for diagnosing, monitoring or assisting with procedures, while standards F-K will be applied to organizations providing only diagnostic imaging services.

17.B This standard was revised to incorporate ultrasonic imaging services, assuring appropriate documentation, maintaining appropriate records or reports of services provided and providing adequate space, equipment and supplies to assure the provision of quality services.

17.C This standard was substantially revised to specify that health care professionals providing imaging services and/or interpreting results have appropriate training and credentials, have been granted privileges to provide these services, and have appropriate safety training and provide their services in a safe manner.

17.D This standard was substantially revised to elaborate on the types of policies that would be required to address the safety aspects of imaging services.

17.E This standard was substantially revised to elaborate on the need to have proper warning signs alerting susceptible individuals to the presence of hazardous energy fields. It also provides a list of such individuals.

17.F This standard was substantially revised to require a radiologist to authenticate all

examination reports, except reports of specific procedures that may be authenticated by specialist physicians or dentists who have been granted privileges by the governing body or its designee to authenticate such reports.

17.G This standard was substantially revised to require that authenticated, dated reports of all examinations performed be made a part of the patient's clinical record.

17.H This standard was substantially revised to require that diagnostic imaging services provided by the organization to be directed by a physician or dentist who is qualified to assume professional, organizational and administrative responsibility for the quality of the services rendered.

17.I This standard was substantially revised to stipulate that diagnostic imaging tests be performed only upon the order of a health care professional.

17.J A new standard was developed to require that diagnostic images be maintained in a readily accessible location for the time required by applicable laws and policies of the organization.

17.K Formerly 17.J, this standard has been re-numbered and revised to include reference to the storage of diagnostic images.

Chapter 24 – Health Education and Health Promotion

The title of this chapter has been amended to include "Health Promotion," replacing "Wellness." In addition, references to "wellness" throughout the chapter have been replaced by "health promotion."

The chapter has also been reorganized and some language revised to include characteristics of health education and health promotion activity that any organization might provide, and characteristics of comprehensive health education and disease prevention programs.

A note was added to the chapter that Standards A-G will be applied to all health education and health promotion services, while Standards A-J will be applied to comprehensive health education and disease prevention programs.

24.C Owing to the significance of the requirement for needs assessments for targeted populations, the reference in this standard has been removed and elaborated in Standard 24-H.

24.H This standard has been substantially revised to specify that health education and disease prevention programs should be based on a complete needs assessment for the population served. These programs have to consider relevant health risks and health education needs, use a variety of data or data sources, quantify risk whenever possible and use data to direct programming.

24.I A new standard has been created to require that health education and disease prevention programs be comprehensive and take into account the medical, psychological, social and cultural needs of the population. It includes a list of suggested topics that should be considered.

24.J A new standard has been created to state that health education and disease prevention programs should be included in quality management and improvement activities.

Appendix B
Right of Appeal—Denial or Revocation of Accreditation

Initial Decision by the Accreditation Committee and Opportunity to Submit Additional Material

Any decision by the Accreditation Committee is reported to the chief medical executive and the administrative head of the organization. If the decision of the Accreditation Committee is to revoke or deny accreditation, such notice will include an explicit statement of the reasons for the decision and generally provide the organization with the opportunity to submit additional material to the Accreditation Committee within 14 calendar days of receipt of the notice. Unless otherwise indicated by the AAAHC, the information provided should be limited to that available at the time of the survey and relative to the standards identified by the AAAHC as less than substantially compliant. The information that is provided will be considered by the Accreditation Committee and the Executive Committee in rendering the accreditation decision.

Final Decision Subject to Right to Appeal

Any decision to deny or revoke accreditation by the Accreditation Committee that is approved by the Executive Committee will be accompanied by an explanation of the reasons for the decision and of the organization's right to a hearing before an Appeals Hearing Panel. Unless otherwise specified by the AAAHC, the panel will be composed of three individuals, designated by the Executive Director of the AAAHC. The panel will not include: (i) any current member of the AAAHC Accreditation Committee or the Executive Committee; (ii) any person who was or ever has been a surveyor of the organization; (iii) more than one director from the AAAHC Board of Directors; or (iv) any person who is in direct economic competition with or has a bias with respect to the organization seeking accreditation. The organization's written request for a hearing must be received within 10 calendar days of the date of the notification along with a one-time nonrefundable payment of $1000 to defray administrative costs incurred in planning and convening the appeals hearing. If the organization fails to request such a hearing on a timely basis, or fails to include payment of $1000 at the time of the request, the decision becomes final. The appeal of any decision is governed by the AAAHC's appeal procedures that are in effect at the time of the appeal.

Hearing Before the Appeals Hearing Panel

A hearing requested by an organization before the Appeals Hearing Panel is ordinarily held within 60 days following receipt of its written request, including the administrative payment of $1000. Approximately 14 calendar days before the hearing, the organization is provided notice of the time and place of the hearing, and the name, specialty and location of the panel members. When the Accreditation Committee decision is based on findings from an AAAHC on-site survey, the organization will also be provided the factual findings included in the survey report. The hearing will be held at the AAAHC office, unless otherwise agreed by the organization and the AAAHC. Panel members may be convened by conference call, and the hearing may proceed with only two of the panel members participating.

At the hearing before the Appeals Hearing Panel, the organization may be accompanied by counsel, make oral presentations, offer testimony and interview any available surveyor(s) who participated in the survey. At least 14 calendar days before any such hearing, the organization may request, in writing, the presence at the meeting of any such surveyor(s) it wishes to interview. Surveyors who are requested to participate in the hearing may be convened by conference call. If the organization makes a written submission to the panel, the submission should be submitted to the AAAHC prior to the hearing. The Appeals Hearing Panel will consider all materials submitted to it on a timely basis. When the accreditation decision is based on findings from an AAAHC survey, the recommendation of the Appeals Hearing Panel will be based on the organization's compliance with the AAAHC's standards at the time of the survey.

Following the hearing before the Appeals Hearing Panel, the organization will be notified promptly of the panel's recommendation. If the panel's recommendation is to uphold the original decision to deny or revoke accreditation, the organization has the right to appeal directly to the AAAHC Board of Directors. The organization's written request for appeal to the Board must be received within ten calendar days from the date of the notification of the Appeals Hearing Panel's recommendation.

If the Appeals Hearing Panel recommends granting accreditation, the organization will be notified of the panel's recommendation, and the Accreditation and Executive Committees will be afforded the opportunity to consider the recommendation of the Appeals Hearing Panel at their next regularly scheduled meetings. Following these meetings, the organization will be notified promptly of the accreditation decision. If the decision to deny or revoke accreditation is not modified or reversed, the organization has ten calendar days from the date of such notice to appeal directly to the AAAHC Board of Directors.

Appeal to the AAAHC Board of Directors,

The Board of Directors will consider any appeal at its first regular meeting that is at least 30 calendar days after receipt of the request for appeal. Members of the Accreditation Committee and the Executive Committee who serve on the Board will not participate in the discussion or the vote by the Board of Directors relative to the accreditation of the organization. Similarly, any AAAHC director who has an interest in the organization, who is a direct economic competitor of the organization, who was a surveyor of the organization, or who was a member of the Appeals Hearing Panel, will not participate in the discussion or vote by the Board of Directors.

The organization may submit, at least 20 calendar days prior to the Board meeting, a written response or comments for review by the Board. The Board will review any such written response and comments submitted, the survey report, and any other materials considered by the Appeals Hearing Panel, and make an accreditation decision that will be final. When the accreditation decision is based on findings from an AAAHC survey, the Board's decision will be based on the organization's compliance with the AAAHC standards in effect at the time of the survey.

Exception with Respect to the Above Appeal Procedures

The AAAHC reserves the right to immediately revoke or deny accreditation before providing notice and an opportunity to submit additional materials or appeal the accreditation decision when, among other things, the organization's failure to satisfy the AAAHC standards may result in imminent danger to the health of any individual or individuals. Under such circumstances the AAAHC shall provide subsequent notice and the opportunity to appeal.

Conditions With Respect to the Appeal Process

An appeal of an accreditation decision generally does not extend or otherwise affect the term of accreditation. If accreditation is revoked, the organization is not accredited during the appeals process. If an accredited organization seeks reaccreditation but is denied, the organization generally remains accredited until the term of the accreditation expires, which could be during the appeals process.

Any appeal conducted pursuant to these procedures requires all parties to act in good faith. An organization's failure to participate in the appeal process in good faith, including, but not limited to, the submission of falsified, incomplete or inaccurate documents or information for any use during the appeal of an accreditation decision may result, at the discretion of the AAAHC Board of Directors, in termination of the organization's right to appeal the decision and immediate termination of the appeal.

No organization may exercise its right to an appeal at the same time that it applies for a new accreditation survey.

Appendix C
Right of Reconsideration

Any decision by the Accreditation Committee that is approved by the Executive Committee is reported to the chief medical executive and the administrative head of the organization. Such notice includes an explicit statement of the reasons for the decision. Any decision to grant a one-year or six-month term of accreditation (excluding an organization undergoing an Early Option Survey), or a deferred decision will be accompanied by an explanation that the organization is entitled to have the decision reconsidered by a Reconsideration Committee. The organization has 14 calendar days from notice of the accreditation decision to submit a written statement requesting reconsideration of the decision to the Reconsideration Committee. If the organization fails to submit a statement, the decision becomes final. Any additional documentation that the organization would like the Reconsideration Committee to include in its deliberation must accompany the organization's written request. Documentation submitted by the organization should substantiate this request and be limited to information believed to be available at the time of the survey and relative to standards identified in the survey report as less than substantially compliant.

The Reconsideration Committee will have 28 calendar days from the date of receipt of the written statement to render its decision affirming or modifying the accreditation decision. A decision of the Reconsideration Committee affirming the accreditation decision is final and is not subject to any further right of reconsideration.

If the Reconsideration Committee grants a longer term of accreditation, the decision will be final and is not subject to any further right of reconsideration.

Due to the costs incurred by AAAHC in reconsideration, the organization may be required to pay the fees established by the AAAHC for such procedures. An organization that fails to pay such fees at the time that it submits a written request for reconsideration will be deemed to have waived its right to reconsideration by AAAHC.

No organization may exercise its right of reconsideration at the same time that it applies for a new accreditation survey.

Appendix D
Quality Management and Improvement Evaluation and Analysis

An accreditable organization maintains an active, integrated, organized, peer-based program of quality management and improvement that links peer review, quality improvement activities and risk management in an organized, systematic way. To assist organizations in developing such a program, the following questions have been developed to assist organizations in evaluating and analyzing their quality management and improvement program.

Subchapter I: Peer Review

An accreditable organization must maintain an active and organized process for peer review that is integrated into the quality management and improvement program. The following questions are designed to assist the organization in assessing its peer review program for overall appropriateness and effectiveness.

	Yes	No
1. Are at least two physicians (or dentists in dental practices) involved in providing peer-based review? If yes, describe. _____ _____	1. ☐	☐
2. If the organization is a solo physician or dental organization, such as an office-based surgical practice, independent practice association or dental practice, is an outside physician or dentist involved in providing peer-based review? If yes, describe. _____ _____ _____	2. ☐	☐
3. Does the organization perform peer review, consistent with its policies and procedures, for allied health care professionals? If yes, describe. _____ _____	3. ☐	☐
4. Does the organization provide ongoing monitoring of important aspects of the care provided by health care professionals, both individually and in the aggregate? If yes, describe. _____ _____	4. ☐	☐
5. Do health care professionals participate in the development and application of the criteria used to evaluate the care they provide? If yes, describe. _____ _____ _____	5. ☐	☐

	Yes	No
6. Does the organization collect data related to established criteria in an ongoing manner and periodically evaluate the data to identify acceptable or unacceptable trends or occurrences that affect patient outcomes? If yes, describe. _____ _____ _____	6. ☐	☐
7. Are the results of peer review activities reported to the governing body? If yes, describe. _____ _____ _____	7. ☐	☐
8. Does the organization use the results of peer review as part of the process for granting continuation of clinical privileges, as described in Subchapter II of Chapter 2? If yes, describe. _____ _____	8. ☐	☐
9. Does the organization provide convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative and research services provided by the organization, and encourage health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures? If yes, describe. _____ _____ _____	9. ☐	☐
10. Does the organization provide a monitoring function to ensure the continued maintenance of licensure and/or certification of professional personnel who provide health care services at the organization? If yes, describe. _____ _____ _____	10. ☐	☐

Subchapter II: The Quality Improvement (QI) Program

An accreditable organization must develop and implement a quality improvement program that is designed to improve organizational performance and the delivery of patient care services. The following questions are designed to assist the organization in assessing its QI program for overall appropriateness and effectiveness.

		Yes	No
1.	Has the organization developed and implemented a written quality improvement program that is broad in scope to address:		
	a. the scope of the organization's health care delivery services and how the QI plan for these services is assessed	1a. ☐	☐
	b. clinical issues	1b. ☐	☐
	c. administrative issues	1c. ☐	☐
	d. cost-of-care performance issues	1d. ☐	☐
	e. actual patient outcomes, *i.e.,* results of care, including safety of patients?	1e. ☐	☐
	If yes, describe how the QI program has addressed each of these above items.		
	_____		
	_____		
2.	Does the organization's QI program identify the specific committee(s) or individual(s) responsible for the development, implementation and oversight of the program? If yes, describe. _____	2. ☐	☐
	_____		
3.	Does the organization's QI program include participation in the program by clinical and administrative personnel, including physician involvement? If yes, describe.	3. ☐	☐
	_____		
	_____		
4.	Does the organization's QI program include specific quality improvement goals and objectives? If yes, describe. _____	4. ☐	☐
	_____		
5.	Does the organization's QI program include development of processes to identify important problems or concerns that are appropriate for improving the quality of services provided by the organization? If yes, describe. _____	5. ☐	☐
	_____		

	Yes	No
6. Does the organization's QI program include identification of quality improvement activities such as studies, including methods for benchmarking performance, to support the goals of the program? If yes, describe. _____ _____ _____	6. ☐	☐
7. Does the organization's QI program define the linkages between quality improvement activities, peer review and the risk management program? If yes, describe. _____ _____	7. ☐	☐
8. Does the organization evaluate the overall effectiveness of the QI program at least annually?	8. ☐	☐
9. Does the organization have processes in place to report findings from the quality improvement activities to the organization's governing body and throughout the organization as appropriate? If yes, describe. _____ _____	9. ☐	☐

Quality Improvement Activities (Studies)

An accreditable organization must conduct specific quality improvement activities, *i.e.,* studies that support the goals of the overall QI program. For each activity that the organization has conducted, the following questions can be used to evaluate the appropriateness and effectiveness of the activity.

1. Does the organization conduct specific quality improvement activities, *i.e.,* studies that support the goals of the QI program? If yes, describe. _____ _____	1. ☐	☐

		Yes	No
2. For each QI activity, is the purpose and significance of the problem(s) or concern(s) that are appropriate for improving the processes or outcomes of care identified?	2.	☐	☐

The purpose of this step in the QI process is to explain the following:

- *What problem exists (or may exist)?*
- *Why is it important to fix the problem?*

Examples or sources of identifiable problems include items a-p below. Check the boxes to indicate whether any of these examples or sources are addressed by your organization's QI studies:

a. unacceptable or unexpected outcomes of ongoing monitoring of care, such as complications, hospital transfers, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, medication errors, specific misdiagnoses, near misses, etc.	2a.	☐	☐
b. the clinical performance and practice patterns of health care professionals	2b.	☐	☐
c. variances from expected performance identified through clinical record review of the quality of care, completeness of entries and/or maintaining clinical record policies	2c.	☐	☐
d. variances from expected results identified by quality control processes, diagnostic imaging, pathology, medical laboratory and pharmaceutical services	2d.	☐	☐
e. other professional, technical and ancillary services provided	2e.	☐	☐
f. assessment of and response to patient satisfaction surveys	2f.	☐	☐
g. direct observation of processes or practices	2g.	☐	☐
h. staff concerns	2h.	☐	☐
i. access to care and/or timeliness of services	2i.	☐	☐
j. medical/legal issues	2j.	☐	☐
k. wasteful practices	2k.	☐	☐
l. overutilization or underutilization of services	2l.	☐	☐
m. prevention, screening, evaluation, treatment or management of prevalent diseases, including chronic conditions, behavioral health, etc., provided by the organization	2m.	☐	☐
n. testing new or enhanced processes or methods of care	2n.	☐	☐
o. benchmarking against best practices, professional practice guidelines and performance measures, or established health care goals	2o.	☐	☐
p. short or long-range planning goals.	2p.	☐	☐

	Yes	No
3. For each QI activity, are performance measures, goals and objectives identified? If yes, describe. _____	3. ☐	☐

The purpose of this step in the QI process is to determine what to measure in order to assess the frequency, severity and source of the known or suspected problem. To determine what to measure, answer the following questions:

- *What data are needed in order to verify:*
  - *Whether the problem actually exists (if this is uncertain)*
  - *The frequency and severity of the problem*
  - *The source(s) of the problem*
- *How will the data be collected?*
- *Against what standard(s) will the data be evaluated?*

4. For each QI activity, are the data related to established criteria used to evaluate and analyze the frequency, severity and source of suspected problems or concerns? If yes, describe. _____	4. ☐	☐

The purpose of this step in the QI process is to determine the gap (if any) between actual and desired outcomes. To determine the gap, collect the data and compare it to the previously identified standard to determine:

- *Whether the suspected problem really exists and, if so…*
- *What do the data indicate about the frequency, severity and source(s) of the problem?*

5. For each QI activity, does the organization implement corrective actions, such as interventions, to resolve important problems or concerns that have been identified? If yes, describe. _____	5. ☐	☐

The purpose of this step in the QI process is to attempt to fix the problem(s), if any, identified in #4 above. This step involves:

- *Determining what must be done differently in order to solve the problem*
- *Implementing of the new processes, procedures, etc.*

	Yes	No
6. For each QI activity, does the organization re-measure the problem to determine objectively whether the corrective actions have achieved and sustained demonstrable improvement? If yes, describe. _____ _____	6. ☐	☐

The purpose of this step in the QI process is to determine the effectiveness of the corrective actions. Here, the data collection and analysis step is repeated to see if the new approach(es) have been successful in solving the problem(s).

7. For each QI activity, has the organization identified, analyzed and implemented additional corrective actions, if the problem remained, to achieve and sustain demonstrable improvement? If yes, describe. _____ _____	7. ☐	☐

The purpose of this step in the QI process is to make additional attempts to fix the problem(s) if the first attempt was not sufficiently successful. If the original attempt(s) to address the problem(s) did not provide the desired results:

- *Determine what else must be done differently in order to solve the problem.*
- *Implement the additional new processes, procedures, etc.*
- *Repeat step 6 to determine if the additional new processes have solved the problem.*

(Note: If repeated attempts to solve the problem do not solve it, it may be time to consider other options, e.g.*, Are the right data being collected? Are the data that have been collected accurate? Etc.)*

8. For each QI activity, has the organization communicated the findings of the quality improvement activities to the governing body and throughout the organization as appropriate, and incorporated such findings into the organization's educational activities? If yes, describe. _____ _____	8. ☐	☐

The purpose of this step in the QI process is to ensure that the governing body, and the organization as a whole, learn from the QI activity and make appropriate changes, as needed. To implement this step:

- *Report the findings of the QI activity to the organization's governing body, and document that this has occurred.*
- *Educate the rest of the organization, as appropriate, regarding the findings and the new systems and/or processes, and document that this education has occurred.*

Performance Benchmarking

An accreditable organization must participate in performance measurement activities as part of its overall quality improvement program. The following questions are designed to assist the organization in assessing its benchmarking activities for overall appropriateness and effectiveness.

		Yes	No
1.	Does the organization's QI program include participation in performance benchmarking activities that allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional target goals? If yes, describe. _____ _____	1. ☐	☐
2.	Do the organization's benchmarking activities include:	2. ☐	☐
	a. the use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served	2a. ☐	☐
	b. systematically collecting and analyzing data related to the selected performance measures	2b. ☐	☐
	c. ensuring the reliability of data	2c. ☐	☐
	d. measuring changes in performance related to the performance measures	2d. ☐	☐
	e. demonstrating and sustaining performance improvement over time	2e. ☐	☐
	f. using benchmarks that are based on local, state or national standards, *i.e.,* performance measures?	2f. ☐	☐
3.	Are the results of benchmarking activities incorporated into other quality improvement activities of the organization? If yes, describe. _____ _____	3. ☐	☐
4.	Are results of benchmarking activities reported to the organization's governing body and throughout the organization as appropriate? If yes, describe. _____ _____ _____	4. ☐	☐

Subchapter III: Risk Management

An accreditable organization must develop and maintain a program of risk management, appropriate to the organization, designed to protect the life and welfare of an organization's patients and employees. The following questions are designed to assist the organization in assessing its risk management program for overall appropriateness and effectiveness.

		Yes	No
1.	Is the governing body of the organization responsible for overseeing the risk management program? If yes, describe. _____ _____	1. ☐	☐
2.	Which person or committee is responsible for the risk management program? _____ _____	2. ☐	☐
3.	Has the organization developed and implemented a risk management program to address safety of patients and the following important issues:		
	a. consistent application of the risk management program throughout the organization, including all departments and all service locations	3a. ☐	☐
	b. methods by which a patient may be dismissed from care or refused care	3b. ☐	☐
	c. reporting, reviewing and appropriate analysis of all incidents reported by employees, patients, health care professionals and others	3c. ☐	☐
	d. periodic review of all litigation involving the organization and its staff and health care professionals	3d. ☐	☐
	e. review of all deaths, trauma or other adverse incidents, including reactions to drugs and materials	3e. ☐	☐
	f. review of patient complaints	3f. ☐	☐
	g. communication with the professional liability insurance carrier	3g. ☐	☐
	h. managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure	3h. ☐	☐
	i. impaired health care professionals	3i. ☐	☐
	j. establishment and documentation of coverage after normal working hours	3j. ☐	☐
	k. methods for prevention of unauthorized prescribing	3k. ☐	☐
	l. processes to identify and/or designate the surgical site and involve the patient in those processes.	3l. ☐	☐

If yes to #3. on the previous page, describe how the risk management program addresses each of the above items (a-l).

		Yes	No
4.	Does the organization conduct a periodic review of clinical records and clinical record policies? If yes, describe. _____ _____	4. ☐	☐
5.	Does the organization provide education in risk management activities to its staff and affiliated persons? If yes, describe. _____ _____	5. ☐	☐

Appendix E:
Sample Credentialing Forms

The sample forms located in Appendices E – I are provided as templates only. Before using any of the sample forms, an organization should review the form in its entirety and determine the appropriateness of its content based on the size and complexity of the organization. Forms may be altered to better meet the needs of individual organizations. Prior to use, it is recommended that all final forms be reviewed by the organization's governing body, or appropriate delegate, as well as legal counsel.

Please note that these sample forms and worksheets are intended to provide guidelines for what may be found in a complete file/record. The items on any given worksheet may or may not be required by the AAAHC standards.

The following samples are provided:

- Appendix E – Sample Credentialing Application, including Privileges Status, Practitioner Peer Reference and Hospital/ Organizational Reference
- Appendix F – Sample Credential Record Worksheet
- Appendix G – Sample Clinical Record Worksheet
- Appendix H – Sample Personnel Record Worksheet
- Appendix I – Sample Office-based Anesthesia Facilities Worksheet

Credentialing Application

(Organization Name)

(Street Address)

(City, State and ZIP Code)

Instructions:

1. **Information must be typed or printed.**
2. **All questions must be answered and forms must be signed where necessary.**
3. **If more space is needed, please attach additional sheets and reference the questions being answered.**
4. **If there is a break in the continuity of your medical education, internship, residency, hospital affiliations, medical practice, etc., please explain.**
5. **Please return the following with your application:**
   a. Copy of current (your state name) license
   b. Copy of Narcotic Registration (Federal/State) (DEA and CDS)
   c. Request for Privileges (completed and signed)
   d. Copy of front sheet of liability insurance policy
   e. Copy of Board Certification (if applicable)
   f. Copy of Hepatitis-B Vaccination or Waiver
   g. Copy of most recent Tuberculosis PPD Test

Identifying Information

Last Name | First Name | Middle Initial | S. S. #

Professional Group Name and Address

City | State | ZIP

Tel. # | Fax # | E-mail

Home Address | Tel. #

City | State | ZIP

Tel. #

Date of Birth | Place of Birth | Citizenship

Physician Providing Coverage | Tel . # | Fax # | E-mail

Medical Licensure/Certification

(Your State Name) License Number | Expires

Controlled Substances Registration Certification Number (Your State Name) | Expires

DEA Number | Expires

Other State Medical Licenses—Past and Present:

State Registration/Number | Date | State Registration/Number | Date

(Organization Name)

(Street Address)

(City, State and ZIP Code)

Premedical Education

College/University | Degrees/Honors

Address | Date of Graduation

Medical Education

Medical School | Degree/Honors

Address | Date of Graduation

Other Professional Education

College/University | Degree/Honors

Address | Date of Graduation

Internship

Hospital | Dates Attended

Address | Full Name of Program Director

Type | Kind (Medical, Surgical, etc.)

Residency(ies)

1.

Hospital | Dates Attended

Address

Description | Full Name of Program Director

2.

Hospital | Dates Attended

Address

Description | Full Name of Program Director

(Organization Name)

(Street Address)

(City, State and ZIP Code) Chair

Training, Fellowships, Preceptorships, Postgraduate Education

List in chronological order. Give complete school or hospital name and address, including ZIP codes; beginning and ending dates; and name of the immediate superior.

1.

School or Hospital | Address

Dates | Superior

2.

School or Hospital | Address

Dates | Superior

3.

School or Hospital | Address

Dates | Superior

Hospital And University Affiliations

List all present and past affiliations in chronological order. Indicate "Staff Status" as: Active/Courtesy, etc. or Academic Title. Use additional sheet if necessary.

1.

Name of Institution | Address

Dates Affiliated | Staff Status

Department | Dept. Chief/Chair (full name)

2.

Name of Institution | Address

Dates Affiliated | Staff Status

Department | Dept. Chief/Chair (full name)

3.

Name of Institution | Address

Dates Affiliated | Staff Status

Department | Dept. Chief/Chair (full name)

4.

Name of Institution | Address

Dates Affiliated | Staff Status

Department | Dept. Chief/Chair (full name)

(Organization Name)

(Street Address)

(City, State and ZIP Code)

Previous Medical Practice

Type	Location (Full Address/Group Name)	Dates Practicing
Type	Location (Full Address/Group Name)	Dates Practicing
Type	Location (Full Address/Group Name)	Dates Practicing

Certification

Certified by American Board of (Specialty)	Certification #	Dates (Certification/Recertification/Expiration)
Sub-specialty Board Status (Name of Board)	Certification #	Dates (Certification/Recertification/Expiration)
If Not Certified, Give Present Status	Date	Date of Exam

Professional Societies, Awarded Fellowships (ACS, ACP, etc.)

List all memberships past, present, or pending in professional societies. Please include date of membership. Please give complete names and addresses, including ZIP codes in all instances. Attach additional sheet if necessary.

Professional Peer References

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference must be from the Chief of the department or service where the applicant last furnished professional services.

1.

Name — Professional Relationship

Address — City — State — ZIP

2.

Name — Professional Relationship

Address — City — State — ZIP

3.

Name — Professional Relationship

Address — City — State — ZIP

(Organization Name)

(Street Address)

(City, State and ZIP Code)

Professional Liability

Insurance Carrier Amount of Coverage

Policy # Agent Expiration Date

Have any professional liability lawsuits been filed against you during the past ten years (including those closed)? ☐ Yes ☐ No

Are there any now still pending? ☐ Yes ☐ No

Has any judgment or settlement ever been made against you in any professional liability cases? ☐ Yes ☐ No

Have you ever been denied professional insurance, or has your policy ever been cancelled? ☐ Yes ☐ No

If yes to any of the above, please explain on separate sheet.

Professional Sanctions

Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, or surrendered? ☐ Yes ☐ No

Have you ever been refused membership on a hospital medical staff? ☐ Yes ☐ No

Has your request for any specific clinical privileges ever been denied or granted with stated limitations? ☐ Yes ☐ No

Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed? ☐ Yes ☐ No

Has your narcotics registration ever been suspended or revoked? ☐ Yes ☐ No

Have you ever been denied membership or renewal thereof, or been subject to disciplinary action (other than discipline for failure to complete medical records) in any medical organization or health insurance plan? ☐ Yes ☐ No

Have you ever received a criminal conviction other than for minor traffic violations? ☐ Yes ☐ No

Have you been sanctioned by either the Medicare or Medicaid program? ☐ Yes ☐ No

If yes to any of the above, please explain on separate sheet.

Health Status

Have you had an illness or physical disability that impairs, or could impair, your ability to practice your medical specialty? ☐ Yes ☐ No

If yes, please explain on separate sheet.

(Organization Name)

(Street Address)

(City, State and ZIP Code)

By applying for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application, and authorize the organization, its medical staff and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the Organization, its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the Organization and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the Organization or to members of its medical staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any information the Organization may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability the Organization for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at the (Organization Name), I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules and regulations of the Organization, as well as the principles, standards and ethics of the national, state and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards." I further agree to abide by the "Governing Standards" as may be enacted from time to time.

In addition, I agree to notify the Organization of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage or Board certification status or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photostatic copy of the requests, authorizations and releases to this application to serve as the original.

Signature of Applicant Date

Print Name

Privileges Request/Granted

_____
(Organization Name)

_____
(Street Address)

_____
(City, State and ZIP Code)

RE: _____
(Applicant Name, Title)

Temporary Privileges

☐ Appointment recommended to the category of _____ staff with clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____
Executive Director

_____ MD/DO
Date Medical Director

Medical Executive Committee

☐ Appointment recommended to the category of _____ staff with clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____ MD/DO
Date Medical Executive Committee Member

Board of Directors

☐ Appointment recommended to the category of _____ staff with clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____ MD/DO
Date Board of Directors Member

Practitioner Peer Reference

(Organization Name)

(Street Address)

(City, State and ZIP Code)

RE: (Applicant Name, Title)

Dear Sir or Madam:

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of (Organization Name). The applicant has given your name as a reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for surgical privileges. Your response will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

	Reliable	Usually Reliable	Problems
Clinical knowledge	☐	☐	☐
Clinical judgment	☐	☐	☐
Technical proficiency	☐	☐	☐
Professional relations with patients	☐	☐	☐
Ethical conduct	☐	☐	☐
Record keeping	☐	☐	☐
Ability to understand and speak English	☐	☐	☐
Participation in medical staff affairs	☐	☐	☐

What is your opinion regarding the applicant's competency in performing the attached requested privileges?

Additional comments:

Recommendation:

Signature Title Date

Name (Please print)

Hospital/Organizational Reference

_____
(Organization Name)

_____
(Street Address)

_____
(City, State and ZIP Code)

Medical Staff Office

Regarding the appointment of: _____
(Applicant Name, Title)

Dear Sir or Madam:

The applicant named above is seeking medical staff privileges at our organization. We would appreciate answers to the questions found below.

This physician's current staff status: _____

QUESTIONS	Yes	No	Do Not Know
Have this practitioner's privileges been restricted, suspended, revoked, or surrendered?	☐	☐	☐
Has this practitioner's professional performance been within or above the acceptable standard of care within the last two years?	☐	☐	☐
Has the practitioner's morbidity rate, mortality rate, infection rate, or complication rate exceeded your organization's criteria for the standards of practice?	☐	☐	☐
Has the practitioner been suspended for medical records violations within the last 2 years? If yes, how many times? _____	☐	☐	☐
Has this practitioner's behavior been disruptive to patient care?	☐	☐	☐
Have there been written complaints about this practitioner by patients, hospital staff, or members of the medical staff?	☐	☐	☐
Has the practitioner been subjected to any disciplinary action by this hospital or licensing body during the past two years?	☐	☐	☐
To the best of your knowledge, has this individual been involved in a malpractice claim or action during the past two years? If yes, please provide us with the information regarding the malpractice claim or action during the past two years.	☐	☐	☐
At the appropriate time, will you likely re-appoint this individual to your medical staff?	☐	☐	☐

Thank you for your effort and assistance with this request.

Signature Title Date

Name (Please print)

Appendix F:
Sample Credential Record Worksheet

Organization _____

Location _____

Date _____

File Identifier

Instructions:

Mark each box as:
- Adequate +
- Inadequate –
- Not Applicable NA

Write all comments on back of worksheet.

Complete, signed application										
Verification of education										
Verification of training										
Verification of Board certification (if applicable)										
Current competence is verified in writing by individuals personally familiar with the applicant's clinical, professional, and ethical performance and, where available, by data based on analysis of treatment outcomes.										
State medical license (or non-physician license or certification) is verified, monitored and documented on an ongoing basis.										
Proof of DEA registration is monitored and documented on an ongoing basis (if applicable).										
Proof of current medical liability coverage meeting governing body requirements (if applicable).										
Information obtained from the NPDB										
Professional liability claims history										
Disclosure of Medicare/Medicaid sanctions										
Immunization records (if required)										
TB testing records (if required)										
Signed attestation releasing organization from liability										
The reappointment process was completed within the timeframe specified by the organization's bylaws (if applicable.)										

Continued on the next page

	File Identifier									
Up-to-date records of CE courses/hours (if required by the organization).										
The credential file was completed in a timely manner.										
List of specific procedures, for which privileges have been granted by the organization for a specified time period, is present.										
If a solo physician practice, the physician's credential file is reviewed by a peer physician.										

Please refer to page 91 for information regarding the use of this worksheet.

Appendix G:
Sample Clinical Record Worksheet

Organization _____

Location _____

Date _____

Chart Number _____

Instructions:

Mark each box as:
- Adequate +
- Inadequate –
- Not Applicable NA
- Write all comments on back of worksheet.

The content and format of record is uniform and consistent.										
The record is legible to clinical personnel with or without assistance.										
The history and physical are adequate based on the chief complaint and other entries in the chart.										
A current list of medications and dosages is present.										
The diagnoses are appropriate for the findings in the history and physical.										
The diagnostic procedures are appropriate based on the diagnosis.										
Treatment is consistent with the working diagnosis.										
Consultation and referrals are appropriate and timely.										
Consent for surgery has been obtained (if applicable).										
Consent for planned anesthesia has been obtained (if applicable).										
Appropriate follow-up is provided.										
For complex and lengthy records, diagnostic summaries are present and used appropriately.										
The presence or absence of allergies, drug sensitivities and materials are clearly and consistently recorded in a prominent and uniform location on a current basis.										
Documentation of follow-up for missed and cancelled appointments is present.										
Laboratory reports, radiology reports and other pertinent information are recorded adequately.										

Continued on the next page

	Chart Number									
Significant medical advice given by telephone is recorded.										
If applicable, operative reports are present, adequate for the procedure and appropriately authenticated.										
Anesthesia records, if applicable, are present and include pre- and post-operative assessment.										
If applicable, records of patients treated elsewhere or transferred to another health care provider are present.										
For dental services, the clinical record includes a comprehensive medical history that is periodically updated which includes an assessment of the hard and soft tissues of the mouth.										
Additional comments (if checked, write comments below with chart numbers).										

Please refer to page 91 for information regarding the use of this worksheet.

Appendix H:
Sample Personnel Record Worksheet

Organization _____

Location _____

Date _____

Instructions:

Mark each box as:
- Adequate +
- Inadequate –
- Not Applicable NA

Write all comments on back of worksheet.

	Record Identifier									
Signed job application or resume										
Job description										
Completed orientation checklist										
Signed acknowledgement of personnel policies & procedures										
I-9 (Immigration and Naturalization Form)										
Verification of references										
Verification of professional license/certification (if applicable) and documentation of ongoing monitoring										
Documentation of completed corporate compliance and HIPAA training										
Documentation of BLS, ACLS, PALS certification (if required)										
Completed criminal background check (if applicable)										
Completed employee benefits forms (if applicable)										
Documentation of annual OSHA in-service training/updates										
Documentation of clinical competencies (if applicable)										
Signed annual/periodic performance appraisals										
Employee Health Records (filed separately)										
Signed Hepatitis-B immunization acceptance/declination										
Documentation of TB testing results										
Documentation of significant workplace exposures, injuries										

Please refer to page 91 for information regarding the use of this worksheet.

Appendix I
Sample Office-based Anesthesia Facilities Worksheet

Instructions:

Mark each box as:
- Adequate +
- Inadequate –
- Not Applicable NA

Write all comments on back of worksheet.

	Facility Location					
The facility complies with applicable state and local building codes and regulations.						
The facility complies with applicable state and local fire prevention regulations.						
The facility contains fire-fighting equipment, including fire extinguishers, to control a limited fire.						
The facility has prominently displayed illuminated signs with emergency power at all exits from each floor or hall.						
The facility has emergency lighting, as appropriate, to provide adequate evacuation.						
The facility has stairwells protected by fire doors.						
The facility conducts and documents four emergency drills per year including one for cardiopulmonary resuscitation technique.						
Smoking is permitted only in designated areas.						
Hazards that might lead to slipping, falling, electrical shock, burns, poisoning or other traumas are eliminated.						
Provisions are made to reasonably accommodate disabled individuals.						
Exam rooms, dressing rooms, and reception areas assure patient privacy.						
Adequate lighting and ventilation are provided.						
Facilities are clean and properly maintained.						
Procedures are available to minimize the sources and transmission of infections.						
A system exists for identification, management, handling, transport, treatment, and disposition of hazardous materials.						

Continued on the next page

	Facility Location					
Space allocated for a particular function or service is adequate for the activities performed therein.						
Appropriate emergency equipment and supplies are maintained and readily accessible to all areas of patient care.						
Equipment is properly maintained and periodically tested.						
Alternate power adequate for the protection of the life and safety of patients and staff is available.						
Additional comments (if checked, write below).						
Date facility was inspected:						

Please refer to page 91 for information regarding the use of this worksheet

Appendix J
Medicare QIO History and Physical Criteria

Chapter 10, Surgical and Related Services, of the *AAAHC Accreditation Handbook for Ambulatory Health Care* provides at Standard E that "An appropriate and current history, including a list of current medications, and dosages if known, physical examination, and pertinent pre-operative diagnostic studies are incorporated in the patient's medical record prior to surgery."

The Medicare Quality Improvement Organization (QIO) program reviews samples of Medicare cases from ambulatory surgery centers (ASCs) and in subjecting them to generic quality screening criteria, among other things looks at adequacy of histories and physicals. Printed below for the reference of users of this *Handbook* is an excerpt from the QIO program's ASC criteria for histories and physicals. These are provided for reference as to Medicare requirements and for anyone wishing further illustrations and guidelines regarding appropriate pre-operative assessment. These are NOT standards of AAAHC, and will not be checked by AAAHC surveyors, but they can be helpful in guiding organizations toward compliance with AAAHC standards in this area.

Was an appropriate history and physical examination completed in a timely manner, *i.e.*, within the 30 calendar days preceding the procedure?

A history should be taken regardless of the type of anesthesia planned or given, as well as when no anesthesia is given. The history should, at a minimum, include documentation of:

1. indication/symptoms for surgical procedure
2. a list of current medications and dosages
3. any known allergies, including medication reactions, and
4. existing comorbid conditions, if any.

Physical Examination. The extent of documentation required in the physician examination is to be reflective of the type of anesthesia planned and/or given, according to the following hierarchy:

1. No anesthesia, or topical local or regional block
   a. assessment of mental status
   b. an examination specific to the procedure proposed to be performed and any comorbid conditions.

2. IV sedation
   a. assessment of mental status
   b. an examination specific to the procedure proposed to be performed and any comorbid conditions
   c. examination of the heart and lungs by auscultation.

3. General, spinal, or epidural anesthesia
   a. assessment of mental status
   b. an examination specific to the procedure proposed to be performed and any comorbid conditions
   c. examination of the heart and lungs by auscultation
   d. assessment and written statement about the patient's general condition.

Note: *Anesthesia combinations require a physical relevant to the highest level of anesthesia provided (*i.e.*, local with IV sedation requires a physical as described for IV sedation).*

On Day of Surgery

There must be a pre-procedure note on the day of surgery by a physician, operating practitioner, or individual qualified to administer anesthesia evaluating the patient's current status for surgery.

Pre-procedure notes on patients undergoing spinal or general anesthesia must also include an anesthesia history.

Laboratory, EKG, and x-rays that are necessary and relevant to the patient's health status and for the procedure being performed are completed and reports available at the time of surgery.

Copies of actual reports or results of each diagnostic study should be in the clinical record. An abnormal laboratory or diagnostic finding that was not addressed appropriately nor resolved prior to surgery is to be reviewed. The patient's health status, comorbid conditions, and type of surgery should be considered when determining what laboratory or diagnostic studies were relevant for this patient.

Blood pressure, pulse, respiration, and temperature should be taken and recorded prior to surgery.

"Prior to surgery" refers to the day of surgery and prior to any pre-operative medication or sedation.

Abnormal results of laboratory, EKG, x-rays, blood pressure, pulse, respiration and/or temperature should either be addressed or resolved or the record should explain why they are unresolved. Abnormal findings are those results which fall outside of normal or acceptable limits for the test or physical findings as defined by the laboratory or facility performing the test.

Appendix K
Malignant Hyperthermia Guidelines

For a list of current agents and further information regarding malignant hyperthermia, contact the Malignant Hyperthermia Association of the United States, 11 East State Street, PO Box 1069, Sherburne, NY 13460-1069, 607/674-7901, *www.mhaus.org*.

To assist organizations, the following official statement was obtained from the MHAUS. “All facilities where MH triggering anesthetics (halothane, enflurane, isoflurane, desflurane, sevoflurane, ether, methoxyflurane, cyclopropane and succinylcholine) are administered (including ambulatory surgery centers and offices) should stock a minimum of 36 vials of dantrolene sodium for injection. If potent volatile agents are not used, and succinylcholine is available for resuscitation, a minimum of 36 vials of dantrolene should be available. If none of these are used or available, then dantrolene need not be present.”

Appendix L
AAAHC Recognized Primary and Secondary Source Verification

Primary Source Verification: Primary source verification is documented verification by an entity that issued a credential, such as a medical school or residency program, indicating that an individual's statement of possession of a credential is true. Verification can be done by mail, fax, telephone, or electronically, provided the means by which it is obtained are documented and measures are taken to demonstrate that there was no interference in the communication by an outside party. Primary sources include:

American Medical Association Physician Master Profile [www.ama-assn.org/amaprofiles]

Certifying Boards[1]

Chiropractic Colleges [Association of Chiropractic Colleges: www.chirocolleges.org]

Dental Schools [ADA list of dental schools: www.ada.org/prof/ed/programs/schools]

Drug Enforcement Agency (DEA) [DEA database: www.ntis.gov/products/families/dea/index.asp]

Medical Schools [Association of American Medical Colleges: www.aamc.org/medicalschools.htm]

Nursing Schools [American Association of Colleges of Nursing: www.aacn.nche.edu/Membership/membdir.htm]

Physician Assistant Schools [American Academy of Physician Assistants: www.aapa.org/pgmlist.php3]

Podiatry Schools [American Association of Colleges of Podiatric Medicine: www.aacpm.org]

Residency and Fellowship Programs [GME programs accredited by the Accreditation Council on Graduate Medical Education: www.ama-assn.org/ama/pub/category/2997.html]

State Licensing Agencies [State medical boards list: www.fsmb.org]

Federation of State Medical Boards [www.fsmb.org]

[1]These sources are for verification of Board Certification only, not education or training.

Secondary Source Verification: Acceptable secondary source verification is documented verification of a credential through obtaining a verification report from an entity listed below as acceptable on the basis of that entity having performed the primary source verification. Information received from any of these sources must meet the same transmission and documentation requirements as outlined for primary sources. Currently acceptable secondary sources include:

American Association of Nurse Anesthetists [www.aana.com]

Specialty Boards of the American Board of Medical Specialties [www.abms.org/member.asp]

Specialty Boards Recognized by the American Dental Association [www.ada.org/prof/ed/programs/specialty/index.html]

Specialty Boards Recognized by the American Podiatric Association [www.apma.org/cpme/specialcertify.html]

American Osteopathic Association Master Profile [http://secure.aoa-net.org/webprof]

American Nurses Credentialing Center [www.nursingworld.org/ancc]

American College of Nurse-Midwives [www.midwife.org]

Educational Commission for Foreign Medical Graduates [www.ecfmg.org]

National Commission on Certification of Physician Assistants [www.nccpa.net]

CVO Reports, provided requirements of Standard 2-II-B-4 are met

Another health care organization, such as a hospital or group practice, that has carried out primary source or acceptable secondary source verification, provided it supplies directly, without transmission or involvement by the applicant or other third party, original documents or photocopies of the verification reports it has relied upon. A statement that it has performed verification is not sufficient.

Documents, diplomas, certificates or transcripts provided directly by the applicant rather than by the primary or secondary source are not acceptable.

Appendix M
History of the Accreditation Association for Ambulatory Health Care, Inc.

A Solid Foundation

A sense of obligation coupled with a willingness to critically evaluate one's own performance is a time-honored tradition of the medical profession. This same tradition is the foundation on which the Accreditation Association for Ambulatory Health Care is built. From this solid base, the Accreditation Association has grown strong and successful through the cooperation, mutual respect and professional pride of its leaders and the physicians, dentists, administrators and other ambulatory health care professionals who have contributed to its efforts and participated in its programs.

The AAAHC was incorporated in 1979, but its history spans more than 27 years of independent and cooperative efforts by many national organizations, all dedicated to high-quality ambulatory health care. This is the story of how those efforts culminated in the formation of the AAAHC and its accreditation program.

American Group Practice Association Concern for Quality

As early as the mid-1960s, the American Group Practice Association (now the American Medical Group Association) began discussing the possibility of establishing a national accreditation program for medical group practices to ensure the provision of high-quality care. AGPA bylaws, in fact, specified that the organization "periodically evaluate the conduct, performance, and quality of medical practice of member clinics in order to certify and accredit them as qualified, comprehensive medical and diagnostic centers."

After considerable study and deliberation, the AGPA Board of Trustees formed its Commission on Accreditation and charged it to develop an accreditation program under AGPA's auspices. In 1968, the Commission began to develop not only standards, but also a method to apply the standards to evaluate the quality of care delivered in ambulatory health care settings.

As the medical record is the physician's primary tool for documenting treatment and communicating with other health care professionals, AGPA focused on it as a way to evaluate ambulatory health care delivery. This was consistent with the Joint Commission on Accreditation of Hospitals (JCAH), now the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which has always emphasized the importance of the medical record in its hospital accreditation programs.

The AGPA also spelled out other essential organizational aspects to be reviewed: the logical process of clinical care, educational activities, research by health care professionals, technological support, qualifications and functions of staff physicians, organizational effectiveness, ethical considerations, and the environment. Other considerations include the size and scope of the practice and its orientation, philosophy, and geographic location. To allow the program to grow with the profession, flexibility was a key factor in the standards and their application.

The AGPA Commission conducted its first on-site visits in 1969 and by September had completed 12 surveys of clinics ranging in size from 7 to 70 physicians. At its annual meeting that year, AGPA awarded its first certificate of accreditation.

During the years that AGPA conducted its accreditation program, the Medical Group Management Association (MGMA) provided health care administrators to participate in the survey process. By the 1976 annual meeting, AGPA had conducted a total of 182 initial surveys and had scheduled 47 additional resurveys, evidence of the growing interest in accreditation.

Change and Cooperative Efforts

A number of interrelated factors influenced the next phase in the development of ambulatory health care accreditation. In the late 1960s and early 1970s, the focus of the health care delivery system began to change, shifting from the hospital to other health care delivery settings. Grants from the federal government spurred this change by funding new centers for primary care. These centers and the burgeoning number of neighborhood health centers and surgical centers found themselves ineligible to participate in any existing, formally organized quality assessment program.

In response to demand for such a program, the Joint Commission and the National Association of Neighborhood Health Centers (now the National Association of Community Health Centers) began to develop standards and survey procedures for these new types of ambulatory health care organizations. At about this same time, the AGPA opened its accreditation program to nonmembers and began to explore the feasibility of forming an accreditation program for ambulatory health care within the Joint Commission's structure.

In early 1974, the Joint Commission, in response to AGPA's interest, approved the formation of the Accreditation Council for Ambulatory Health Care. The Council was formally organized in May 1975, with its founding members representing the American Group Practice Association, American Hospital Association, American Medical Association, Group Health Association of America and the Medical Group Management Association. Financial support for the Council's development was secured from the W. K. Kellogg Foundation and the Robert Wood Johnson Foundation.

Other Voices and New Horizons

College Health

The American College Health Association (ACHA) began to consider a quality assessment program for its member health centers at about the same time that AGPA began developing its accreditation program in the mid-1960s. Because health centers on college campuses were frequently responsible for occupational and environmental health, sanitation, health education, and other activities besides direct patient care services, the ACHA's standards focused on the health service and its relationship to the entire institution. And, for the first time, mental health services received considerable attention in standards for ambulatory health care organizations.

ACHA conducted a pilot survey in 1967. The pilot was successful and ACHA launched its certification program. Over the next 13 years, more than 80 college and university health centers were surveyed.

Ambulatory Surgery

In 1974, because ambulatory surgical facilities were not eligible for survey by JCAH, the Society for the Advancement of Freestanding Ambulatory Surgical Care (now the Federated Ambulatory Surgery Association) identified the need to develop voluntary standards for its members.

Although many of the existing ambulatory health care standards were applicable to surgery centers, additional standards were needed for surgical and nursing care, the administration of anesthesia, and the environment of the operating room. FASA was also interested in developing standards for the cost of care and the use of alternative resources.

In 1975, FASA began to develop an accreditation program for ambulatory surgery centers. In the first year of operation, FASA surveyed 10 organizations.

Renewed Commitment

In October 1978, when the Joint Commission decided to dissolve its accreditation councils and to replace them with professional and technical advisory committees, representatives from the member organizations of the Accreditation Council for Ambulatory Health Care urged JCAH to modify its plans. They suggested several alternatives that would keep the ambulatory accreditation program intact, alternatives that were consistent with most aspects of the JCAH's reorganization plan. The JCAH, however, reaffirmed its decision to reorganize.

Most of the member organizations of the Accreditation Council for Ambulatory Health Care were unable to accept the loss of responsibility and authority that their original agreement with JCAH had ensued. The feeling of ownership of the program was especially strong because of the previously existing programs and the expertise these member organizations had brought to the Accreditation Council. Thus, they withdrew from JCAH.

The American College Health Association, which had begun discussions with JCAH about cooperative accreditation efforts, suspended its discussions when JCAH reorganized. Likewise, the Federated Ambulatory Surgery Association suspended its pursuit of cooperative efforts with JCAH.

AAAHC Is Founded

The Accreditation Association for Ambulatory Health Care, Inc. was incorporated in Illinois as a not-for-profit corporation on March 22, 1979. Its purpose, as stated in its certificate of incorporation, is to organize and operate a peer-based assessment, education and accreditation program for ambulatory health care organizations as a means of helping them provide the highest achievable level of care for recipients in the most efficient and economically sound manner.

Specifically, the corporation is organized to:

a. conduct a survey and accreditation program that will promote and identify high-quality, cost-effective ambulatory health care programs and services

b. establish standards for accreditation of ambulatory health care organizations and services

c. recognize compliance with standards by issuance of certificates of accreditation

d. conduct programs of education and research that will further the other purposes of the corporation, to publish the results thereof, and to accept grants, gifts, bequests and devices in support of the purposes of the corporation

e. provide programs that will facilitate communication, sharing of expertise, and consultation among ambulatory health care organizations and services

f. assume such other responsibilities and conduct such other activities as are compatible with such survey, standard-setting, accreditation and communication programs.

The six charter members of the corporation were the American College Health Association, the American Group Practice Association (now known as the American Medical Group Association), the Federated Ambulatory Surgery Association, the Group Health Association of America (now known as the American Association of Health Plans), the Medical Group Management Association, and the National Association of Community Health Centers. Each of the organizations designated AAAHC as its national accrediting body, appointed members to the Board of Directors, and contributed funds to the development and operation of the program.

Since the AAAHC's founding, both the American College Health Association and the Federated Ambulatory Surgery Association have discontinued their own accreditation programs in order to fully support the AAAHC program.

Responsiveness to a Changing Profession

True to its basic purpose, the AAAHC has over the years continued to expand its horizons to meet the changing needs of ambulatory health care organizations. In 1982, the AAAHC Board of Directors approved the addition of a new member organization, the Outpatient Ophthalmic Surgery Society.

In 1983, the American Academy of Facial Plastic and Reconstructive Surgery, the National Association of Freestanding Emergency Centers (now the National Association for Ambulatory Care), and the Society for Office Based Surgery (now the American Society of Outpatient Surgeons) were accepted for membership on the AAAHC Board of Directors.

In 1984, the American Association of Health Plans withdrew its membership.

In 1987, the American Occupational Medical Association (now the American College of Occupational and Environmental Medicine) joined the AAAHC. Standards were developed for occupational health services, and the AAAHC began the survey and accreditation of industry-based occupational health services. These new standards were also applied to all other organizations that provide occupational health services.

Also in 1987, the American Academy of Dental Group Practice voted to discontinue its own accreditation program for dental group practices and became a member of AAAHC.

The year 1989 saw a number of significant developments. Three new organizations became members of the AAAHC: the American Association of Oral and

Maxillofacial Surgeons, the American Academy of Cosmetic Surgery, and the Association of Freestanding Radiation Oncology Centers. Two organizations—the National Association for Ambulatory Care and the American Group Practice Association—withdrew their memberships, but both remain supportive of accreditation for their members.

In 1993, the AAAHC Board of Directors approved the addition of the American Society for Dermatologic Surgery as its newest member organization.

In 1994, the AAAHC Board, in order to hear input from outside the medical community in a more structured way, adopted a bylaws amendment permitting one or more public members to serve on the AAAHC Board. AAAHC's first public member, an executive on the health benefits corporate staff of Amoco Oil Company, was added to the AAAHC Board in the fall of 1994.

And to enhance communications and interchange with the broad-based constituencies of organized medicine and dentistry, in 1995, at the AAAHC's invitation, the American Medical Association and the American Dental Association both began sending official observers to meetings of the AAAHC Board of Directors.

Since 1999, the AAAHC Board approved the addition of the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American Society of Anesthesiologists, the Society for Ambulatory Anesthesia and the American Academy of Dermatology. In 2001, the Association of Freestanding Radiation Oncology Centers withdrew its membership, followed by the American College of Occupational and Environmental Medicine in 2003. Both organizations continue to remain supportive of the AAAHC and its accreditation program. In 2004, the American Gastroenterological Association became a member of the AAAHC Board, while the American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy became the latest members when they joined in 2005. In the same year, however, the American Academy of Family Physicians withdrew its membership.

The AAAHC continues to review its standards and survey procedures to ensure their relevance to the ever-changing health care profession. Pilot programs are developed to test the applicability of the standards and procedures to new settings.

The AAAHC has always provided educational programs and presentations at major ambulatory health care meetings each year. In response to an expressed need for more training and education in quality assurance and accreditation standards and procedures, we have implemented full-length educational programming sponsored to supplement the workshops at other ambulatory organization meetings.

Although change is an inherent part of its philosophy, the AAAHC's basic principles remain firmly intact. The AAAHC intends to continue its tradition of using physicians, administrators, and other health care professionals who are actively involved in ambulatory health care to conduct its accreditation surveys.

Since its founding, the AAAHC has conducted thousands of accreditation surveys of all types of ambulatory care organizations, including ambulatory surgery facilities, college and university health services, community health centers, single and multispecialty group practices, and health maintenance organizations. In this regard, it is significant to note that in September of 1996, the AAAHC became the first accreditation organization to conduct an accreditation survey of a pure Independent Physician Association.

Because of the quality of its standards and the thoroughness of its surveys, the AAAHC has been recognized and accepted by all types of third-party payers (Blue Cross and Blue Shield plans, commercial carriers, HMOs, governmental agencies) as meeting their conditions for participation in reimbursement programs. In recognition of the requirements for risk control and a quality assurance program in the AAAHC's standards, a number of major professional liability carriers extend a discount in premium coverage to ambulatory surgery centers and to single and multispecialty group practices accredited by the AAAHC.

Of utmost significance was the recognition of the AAAHC by the Centers for Medicare & Medicaid Services (CMS), formerly known as HCFA, on December 19, 1996, in granting the organization "deemed status" for Medicare certification for ambulatory surgery centers. In July 2006, CMS again recognized the AAAHC and its accreditation program when it renewed the AAAHC deemed status for health maintenance organizations and preferred provider organizations that participate in the Medicare Advantage (previously called Medicare+Choice) program.

In 2002, the AAAHC partnered with the American Lithotripsy Society (ALS) to develop a specialized program for the accreditation of lithotripsy organizations. The first lithotripsy organization completed the program and was awarded accreditation in 2003.

The Future of the AAAHC

Since its founding, the AAAHC's accreditation program has steadily gained acceptance and recognition from the health care community, government and general public. Now it has established itself as a leader in the maintenance and development of high-quality, cost-effective health care in the United States.

In 2004, while celebrating its 25th anniversary, the AAAHC reached a milestone in the number of currently accredited organizations, which reached 2000 in November. The number has since grown by leaps and bounds and a new thousandth milestone is likely to be reached very soon. The continued growth and success of the AAAHC are ensured because of the commitment of ambulatory health care professionals to improve the quality of care provided in their organizations, to compare their performance with recognized standards, and to share their experiences through education and consultation.

The leaders and participants in the AAAHC believe that a voluntary, pluralistic, peer-based approach will continue to improve health care services by fostering innovation and providing motivation. Above all, they believe that the ultimate beneficiaries of accreditation will always be the patients they serve.

Appendix N
AAAHC Members and Leadership

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) comprises of the following organizations:

American Academy of Cosmetic Surgery (AACS)
American Academy of Dental Group Practice (AADGP)
American Academy of Dermatology (AAD)
American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS)
American Academy of Opthalmology (AAO)
American Association of Oral and Maxillofacial Surgeons (AAOMS)
American College of Gastroenterology (ACG)
American College Health Association (ACHA)
American College of Mohs Micrographic Surgery and Cutaneous Oncology (ACMMSCO)
American College of Obstetricians & Gynecologists (ACOG)
American Gastroenterological Association (AGA)
American Society of Anesthesiologists (ASA)
American Society for Dermatologic Surgery (ASDS)
American Society for Gastrointestinal Endoscopy (ASGE)
Foundation for Ambulatory Surgery in America (FASA)
Medical Group Management Association (MGMA)
Society for Ambulatory Anesthesia (SAMBA)

Public Member

Christopher Strayhorn, MD,
National Association of Community Health Centers (NACHC)

Official Observers

American Medical Association
American Dental Association

Officers

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Gerald Edds, MD, 2003-2005
C. William Hanke, MD, 2001-2003
William Beeson, MD, 1999-2001
Margaret W. Bridwell, MD, 1997-1999
Bernard A. Kershner, 1995-1997
Sam J.W. Romeo, MD, MBA, 1993-1995
Frank J. Newman, MD, 1991-1993
Carl J. Battaglia, MD, 1989-1991
Nicholas D. Wing, MD, 1987-1989
David J. McIntyre, MD, 1985-1987
John R. Johnson, 1983-1985
Wallace A. Reed, MD, 1981-1983
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Roy C. Grekin, MD, 2005–2006
Gerald Edds, MD, 2001-2003
C. William Hanke, MD, 1999-2001
William Beeson, MD, 1997-1999
Margaret W. Bridwell, MD, 1995-1997
Bernard A. Kershner, 1993-1995
Sam J.W. Romeo, MD, MBA, 1991-1993
Frank J. Newman, MD, 1989-1991
Carl J. Battaglia, MD, 1988-1989
Joseph C. Belshe, MD, 1987-1988
Nicholas D. Wing, MD, 1985-1987
David J. McIntyre, MD, 1983-1985
F. Daniel Cantrell, 1981-1983
Wallace A. Reed, MD, 1979-1981

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John R. Johnson, 1981-1983
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